The meaning of re-emerging disordered eating in the context of motherhood: An Interpretative Phenomenological Analysis.

Adi Hannah Sela
U1713394

A thesis submitted in partial fulfilment of the requirements of the School of Psychology, University of East London for the Degree of Professional Doctorate in Counselling Psychology

April, 2021

Acknowledgements

I would like to express gratitude to my research supervisor, **Dr. Cristina Harnagea**, for the many hours you dedicated on reading my lengthy drafts, and for your constructive feedback. I am lucky to have had a research supervisor encourage me so, through a serene attitude and a wonderful sense of humour. I was also fortunate to be supported by **Dr. Lisa Fellin** who challenged me to think through my research decisions, and who was there to instil me with hope when looking for participants.

To **each and every single participating mother** – thank you for sharing your valuable time with me and your invaluable experiences and insights. I will never forget the warmth and openness that I felt in our interviews, and I hope that I have done justice to the experiences you voiced.

To my **fellow CoP trainees**, I feel blessed for having met each and every one of you. A carefully selected group of intellectual and empathetic individuals, who spurred me on and inspired me in more ways than you know. Thank you for having my back and providing me with a home away from home. A special thank you to **Maria Bermeo**, who made me laugh and brought flexibility and ease to my studies. You never failed to entertain my need for mind-stimulating discussions that undoubtedly supported my growth and development in the doctorate, and equally as an individual.

Last but definitely not least, to my family who supported me every step of the way, and whose belief in me is what brought me to pursue a doctorate in the first place. To **my mom**, for being my inspiration for this thesis, and for knowing when to hold me and when to push me forward. To **my dad**, for supporting me in every way possible and unconditionally, and making sure I was never too harsh on myself. To **my older sister**, who encouraged my growth as an individual and a professional throughout the doctorate, and who did not let geographical distance get in the way of accompanying me every step of the way. Thank you for always having my back, for your empowering curiosity in my experiences and your priceless camaraderie. To **my little sister**, whose soul and heart (well-beyond her years) oversaw the entire write-up, in intellectual and emotional ways that nobody else would have been able to offer. You have been, and continue to be, the light in my life, helping me glide through challenges and moments of frustration.

Abstract

This study aimed to explore the experiences of re-emerging disordered eating (DE) in the context of motherhood. My rationale for undertaking this endeavour was based on the dearth in anonymous studies on experiences of re-emerging DE in motherhood beyond the post-partum period, and conflicting findings regarding remission and relapse following pregnancy. Theories of control, emotional regulation, and identity formed part of the theoretical framework with which I presented previous literature, and contributed to my rationale for the research question: "what is the experience of re-emerging DE in the context of motherhood?" To explore this question and to expand the diversity in relevant literature, I conducted semi-structured interviews with seven Israeli participants in the Hebrew language. Participants ranged from 24 to 47 years old and were biological mothers for one to four children. Following transcription, I translated interviews and analysed data using the methodology deemed most appropriate; Interpretative Phenomenological Analysis. The analysis gave rise to three super-ordinate themes: "Motherhood as healing to DE", "Motherhood as triggering to DE", and "Good enough vs. thin enough mother". Each of these super-ordinate themes consisted of three to four sub-ordinate themes.

One of the key novel findings in this study is the constant push-and-pull between managing DE and motherhood demands and throughout motherhood (i.e., beyond pregnancy and the post-partum period). A reflection on both the 'good' and 'bad', as well as 'confusing' relationship between DE and motherhood shed light into the previously observed fluctuations in DE presentations in mothers. Another novel finding was the continuous interplay between DE and motherhood, such that participants described coping with 'guilt about DE in motherhood' with further DE pre-occupation and/or behaviours. These findings point to the complex nature of re-emerging DE in motherhood. Furthermore, these findings emphasise the need for support to focus on the individual experience of the mother, and in-so-doing reduce shame and stigma that often prevents access to help and that may exacerbate DE struggles.

In order to offer relevant support, and to learn from individual experiences, I have made recommendations for clinical practice to explore and normalise experiences for mothers as reactive care (i.e., to mothers struggling with DE) and as preventative care (i.e., to women planning to be mothers). In order to inform guidelines, I suggest areas for future research to check for the commonality of the experiences described by my participants. Considering the context of my study and that participants mentioned conflicting societal demands,

recommendations for future research also included research focusing on discourse in line with different epistemologies. My focus on phenomenological and idiosyncratic experience is acknowledged throughout the study and its implications, as aligned with my constructivist epistemological and phenomenological approach.

List of Tables and Figures

Abbreviations

BPS: British Psychological Society
CoP: Counselling Psychology
DE: Disordered Eating
ED/s: Eating Disorder/s
IPA: Interpretative Phenomenological Analysis
UEL: University of East London
UK: United Kingdom

TABLE OF CONTENTS

Introduction

Chapter Overview

In this Introduction Chapter, I will set the context which frames the doctoral research I have undertaken about the experience of re-emerging DE in the context of motherhood. I consider my personal context, my philosophical positioning as a researcher, and my study's relevance to CoP.

Personal Context

Though my chosen methodology does not assume to 'bracket' personal experiences, it is nonetheless valuable to consider how our previous experiences may predispose us to consider certain phenomena over others, and the way in which we approach these.

As a daughter of a mother who struggled with DE since her adolescence, I became increasingly aware of how her attitudes towards her own body shape, size, weight and diet instilled in myself and my siblings a relationship with these aspects that was different to my peers'. As an adolescent, I recall having spoken to my mother about her comments to myself and my sister seemingly in an attempt to 'prevent' us from experiencing DE through controlling our weight, diets and exercise. Considering my mother's experiences in society and the thinness ideal as part-and-parcel of the cultures she and I were raised in, I can now empathise with her concern that her children being overweight may 'cause' suffering and DE. Paradoxically, in our upbringing, my sibling and I experienced this attempt to 'control' as what introduced an unnatural focus on these topics such that we would often hide foods from our mother, thus resulting in unhealthy weight. In essence, we noticed how my mother's fear of our developing DE by preventing our being over-weight became a self-fulfilling prophecy. As an adult with friends who are mothers, and as someone providing therapy to mothers, I observed a fear of being perceived as mentally 'unhealthy', as well as a common discourse on 'losing the baby belly' upon giving birth. Taken together, I wondered what my mother might have experienced when my sister and I confronted her for her DE-related comments and behaviours; was she ashamed? I considered that the denial of the comments may have been out of fear of being considered a 'bad mother', and whether our attempts at 'interventions' missed the point. That is, that DE is rarely within the individual's control or choice. Considering my mother's good intentions, I sought to understand the experience of DE in motherhood. In my undergraduate studies, I was interested in EDs, and literature reviews I conducted revealed a focus on preventing 'passing on' of EDs to children. Time after time, I noticed the lack of focus on the mother's experience. Considering the societal

pressures on restoring the pre-baby body, as well as the all-too-present expectation for mothers to always know how to nurture and care, and not to struggle with mental health, I became passionate about normalising and providing support for mothers struggling with DE.

Positioning as a Researcher

In this section, I outline research within CoP by thinking about popular research methodologies in the field and how I position my epistemology in relation to these.

Popularity of research in psychology is believed to have begun once its pioneers adapted theories used in medicine (for the treatment of body ailments) to apply to psychology and psychiatry (for the treatment of mental ailments; Szasz, 1974). The recognition of psychology as a science required research to be conducted similarly to that of medicine or other scientific practices. As the causal-deterministic model had informed most other scientific fields, research by and large sought to "prove" or "discover" a reality. Researchers assumed that reality can be said to exist when the same 'reality' is 'found' over and over again, and not just in an isolated incident. Therefore, research in these fields was considered reliable, valid, and valuable if it employed quantitative methods with large samples. Underlying these methods and methodologies are stances of realism and positivism which stipulate that concrete realities or 'truths' exist objectively and that our knowledge of reality is a direct outcome of what reality 'is'.

While positivist epistemology gave rise to the 'scientific' research and practice in the field of psychology, many professionals progressively acknowledged a tension between the epistemology reflected in its research to that reflected in practice.

I identify with the humanistic values underpinning therapeutic practices of CoP: the individual's experience is at the heart of therapy (The British Psychological Society, 2017a). My own epistemology, and similar to the underpinnings of CoP, differs from positivism as I believe that subjectivity has an impact on experience. This is more obvious in the practice side of CoP; I believe therapy to be experienced differently for every person or at any given time, and so, there are multiple 'realities'. This attitude is common in the field of CoP; an epistemology that can be placed somewhere in between 'positivism' and 'relativism' on the spectrum of stances. The precise 'location' on the spectrum depends on the practitioner/researcher, and in my case, I identify with a critical realist ontology and a constructivist epistemology, within the realm of phenomenology.

It is in accordance with my position that I value all research in the field, and cannot assume one epistemology or methodology to be superior or exposing more 'truth' to another, as this in itself would contradict my positioning. I appreciate a wide array of research that takes from varying ontologies and epistemologies, and that these would embody an epistemological coherence throughout such that claims are in line with a study's aims. As a scientist-practitioner, I value research in informing my practice and developing the field, as well as paying attention to the idiosyncratic needs of my clients, and the specific participants involved in a given project.

Counselling Psychology Context and Rationale

A better understanding of how mothers make sense of their re-emerging DE in the context of motherhood may contribute to more personalised therapy. Such therapy would be cost-effective as it would address triggers for afflicted mothers, and could prevent relapse that may take place after therapy concludes (vis-a-vis predicting motherhood challenges). Furthermore, at-risk mothers may be approached early on (e.g., through fertility clinics) and therapy in this case may prevent worsening of symptoms.

My chosen methodology does not permit for generalisations to the wider population of mothers with DE, due to its small size as well as idiographic and phenomenological nature. Nonetheless, it justifies transferability conclusions (Pietkiewicz & Smith, 2014). As such, results could inform therapy for women reporting similar experiences to those reported in my study. However, such a statement clashes with my phenomenological stance in that it would contradict the subjective perception and meaning-making of a given mother in forming her experience. Yet, it is important to start to understand mothers' meaning-making of DE in the context of motherhood, in order to better support mothers and to prevent dangerous ED symptoms. Despite qualitative data being limited in sample size, and therefore limiting the conclusions that can be drawn to the wider population, the richness of data may help to build this body of knowledge and to further relevant research and practice (Harper & Thompson, 2011).

By conducting this research in Israel and interviewing in its native language (i.e., Hebrew), I am contributing to diverse research on DE in motherhood.

Chapter Summary

Through this thesis I aimed to explore the experience of re-emerging DE in the context of motherhood. In this introduction, I overviewed the relevance of this exploration to my personal context, my positioning as a researcher, CoP practice and diversity of research.

Literature Review

The experience of re-emerging DE in the context of motherhood

In a society where motherhood is encouraged, but where copious expectations are placed on mothers in order to be perceived as 'good enough mothers' (Heisler & Ellis, 2008), and as safe for their children, the transition into motherhood is unsurprisingly often accompanied by feelings of stress and anxiety. Previously seen by others and herself as a 'person' and a 'woman', the new mother must grapple with her new identity as a mother and the responsibilities that tag along (Bailey, 1999). As such, the new mother must place the well-being of her child as a first priority, whilst still caring for herself in order to be able to exist as a mother. Throughout this transition, multiple challenges arise that introduce a wide array of changes to the way the mother experiences her day-to-day life. These include hormonal and bodily changes, mood shifts (especially during the post-partum period), employment adjustments, and other changes that follow (Baistow, 2007). Despite attention from medical staff (e.g., doctors and nurses), and perhaps care from close individuals in the soon-to-be mother's life (e.g., romantic partners, parents), such attention is usually geared towards ensuring the baby's health and safety. As the mother is usually seen as the primary caregiver, and during pregnancy she is seen as the carrier, supportive people in the soon-to-be mother's life usually expect her to make sure she is providing the right environment and is taking proper care of her offspring. If there is reason to believe that the mother is not meeting such expectations, professionals may intervene (e.g., doctors, social workers) and in extreme cases, separate the offspring from their mother. Such entangled expectations often make it difficult for new mothers to seek out help, considering the ambiguity, uncertainty, and fragility of safeguarding of children (Bye et al., 2018). In essence, this tension comprises of yet another challenge mothers must face; how to cope with challenges of motherhood in a socially acceptable manner (Henderson et al., 2016; Lupton, 2011). This process may be faced with low mood and anxiety, which is often worsened by a lack of support from medical professionals and the aforementioned fear to discuss difficulties (Clement et al., 2015). For any mother who has added difficulty with any of the changes, coping in a 'healthy' and 'socially acceptable way' becomes even harder to navigate. As many motherhood changes are bodily and are out of the mother's control, one can already see a potentially triggering event for mothers with a history of DE.

Key constructs: disordered eating and motherhood

Disordered eating. Generally speaking, EDs are diagnostic labels used in psychiatry in order to treat individuals who struggle with their relationship to food, weight, and their body's shape and size. The way in which individuals manage these struggles defines the specific labels of EDs. For example, someone diagnosed with Anorexia Nervosa (AN) tends to manage their struggle by restricting food intake, whereas someone diagnosed with Bulimia Nervosa (BN) may do so by purging after a binge (American Psychiatric Association, 2013). There is also a range of presentations that do not fall under a label of AN or BN, and may end up understood as 'Other Specified Feeding or Eating Disorder' (OSFED; American Psychiatric Association, 2013). These latter categories were known as 'Eating Disorders Not Otherwise Specified' (EDNOS) in the 4th edition of the Diagnostic Statistical Manual (DSM; American Psychiatric Association, 2000). Regardless of the specific ED diagnostic label, we can say that these individuals experience eating disturbances. In the literature review, I will mention and critique research conducted with diagnoses of EDs, as well as the subjective self-reported experience of DE. DE is a general umbrella term comprising of distressing struggles with eating behaviours and attitudes that correspond with the criteria of diagnosis for EDs. To clarify, DE does not equate to OSFED/EDNOS. It does not necessarily refer to cases where a diagnosis of an ED is almost met but not quite. Rather, it views the same distress in terms of a subjective self-report of a general category to do with diet, weight, body shape and/or body size. In this sense, someone with a diagnosis of an ED would be struggling with DE, but the reverse is not always true.

Motherhood. Traditionally, the moment a woman gives birth she is biologically considered a mother. However, the transition to motherhood does not only include the biological but also the personal, mental and social changes that coincide (Smith, 1999).

In fact, the motherhood mindset is thought to develop through a number of stages (Mercer, 2006). In Stern & Bruschweiler-Stern's view (1998), this is a three-part process, which includes (a) pregnancy, (b) the first months after birth and (c) the integration of the mother identity into a woman's life.

In this literature review, I present my rationale to focus on the experience of DE in motherhood by considering the overlapping elements between motherhood and DE. For the purpose of clarity, literature will be divided into two phases of motherhood: (a) pregnancy, and (b) post-partum and beyond. Despite theories on the three-part process of motherhood, literature on motherhood and DE has tended to cleave the biological and psychological

aspects of motherhood. Therefore, relevant research has tended to investigate either "pregnancy and post-partum" (under the biological paradigm) or "post-partum and beyond" (under the psychological paradigm).

Control, emotional regulation and identity

Common among the ED diagnoses, and therefore cutting across DE, are the triggers and reasons behind the behaviour employed. That is, the manifested behaviours (e.g., purging, restricting) are thought to emerge in order to instil a sense of control (Button & Warren, 2001). Studies have shown, for example, that the onset of EDs is often around a time in which individuals feel a loss of control in their lives (e.g., grief, major life changes, sexual abuse, etc; Fairburn et al., 2003; Fox & Power, 2009; Polivy & Herman, 2002). The same phenomenon has also been understood such that individuals who undergo intense pressure, stress, and negative emotions, learn to regulate these through their eating disturbance (Corstorphine, 2006; Fairburn & Harrison, 2003; Goss & Allan, 2009; Harrison et al., 2010; Hooker & Convisser, 1983). For example, some studies indicate that a short-term relief in negative affect is experienced following purging, restricting, or binge eating (Fox & Power, 2009; Freeman & Gil, 2004; Polivy & Herman, 2002). Yet another interpretation is that when major life events lead us to question central aspects of our identities, individuals may find solace in developing an ED identity (Hooker & Convisser, 1983; Polivy & Herman, 2002). Therefore, much research has indicated that DE may develop or be relied upon as a way to regulate negative emotions, or to exert control over seemingly chaotic life events (Fox & Power, 2009; Freeman & Gil, 2004; Harrison et al., 2010; Hooker & Convisser, 1983). Becoming and being a mother may present a myriad of challenges that may indeed elicit negative emotions. These include not only the hormonal and biological changes that take place during pregnancy and/or aging (Baistow, 2007), but extend to economic, social, and psychological challenges that may arise throughout motherhood (Harrison et al., 2019). For example, many mothers struggle to balance work demands and dreams with mothering responsibilities (Johnston & Swanson, 2006; King & Botsford, 2009). Yet another set of challenges might relate to maintaining other relationships, while still managing motherhood in terms of societal expectations (e.g., putting children first, serving as a continual role model, etc.; Heisler & Ellis, 2008). Similarly, mothers may struggle with integrating the "mother" identity with their "self", and creating a balance that is both socially acceptable and personally suitable (Bailey, 1999). Furthermore, children's needs vary across the lifespan and from child to child (Feldman, 2017). As such, mothers fine-tune to their children's needs and

adjust their own lives (Miller, 2005). These are just a few of the adjustments and potential challenges of motherhood, possibly eliciting negative emotions, and/or being perceived as out of the mother's control.

Secrecy and stigma

Considering that DE often requires a degree of secrecy in order not to be noticed and intervened by others (Goss & Allan, 2009), this compounds the degree of secrecy a mother would need to employ if she is experiencing DE. Therefore, many mothers may experience high levels of shame of their DE (Troop et al., 2008), and, due to the focus on the child as the highest priority (by the mother and society), may fear disclosing their difficulties to a medical professional or even a close relative. And, when the mother is no longer closely monitored by a medical staff (i.e., during pregnancy, child-birth, and the post-partum period), this may further limit the opportunities available to consider disclosing her difficulties. As such, afflicted mothers may be harder to identify and reach, and therefore receive limited support to help treat their DE. Left untreated, DE tends to spiral as certain behaviours become addictive (Frank, 2013), and as the ambivalence towards treatment grows (Juarascio et al., 2010; Stockford et al., 2007). Since DE often involves physically damaging behaviours (e.g., purging, restricting, over-exercising), resultant medical damage (e.g., intestinal) and starvation often lead to death (Crow et al., 2009; Smink et al., 2012). Therefore, it is important to identify, reach out to, and support mothers with DE, as early as possible.

At present, there is a dearth in research on mothers with DE after the post-partum period, and as such, there is a lack of knowledge on the interaction between motherhood and DE. By interviewing mothers in an environment where shame is reduced (i.e., through anonymised online recruiting and data collection), it may be easier to recruit such mothers.

By learning from these mothers how they experience their DE in the context of motherhood, CoP practices may be able to develop preventative therapeutic interventions for young women presenting with DE, such that struggles may be coped with better in the future, if and when the woman is to be a mother. Furthermore, tailored therapeutic interventions may help normalise this difficulty and as such, reduce fear of stigmatisation for affected mothers, who might then be more likely to seek out psychological support.

Literature Review Findings

Focus on the child

Much research involving mothers and EDs has focused on the consequences and implications that mothers' symptoms have on children (e.g., Patel et al., 2002; Polivy & Herman, 2002). A great deal of this research is focused on the resultant medical consequences observed among children. For example, Bulik et al. (2009) associated affected mothers' physical state (i.e., their BMI during pregnancy) with complications at birth (e.g., having a Caesarean section) and the physical state of the infant at birth (e.g., birth weight, Apgar scores). This study (and others) point out the birth-related difficulties associated with EDs and pregnancy (e.g., Franko et al., 2001; Kouba et al., 2005).

More recent studies focus on neurobehavioural outcomes in infants of ED mothers, emphasising the detrimental effects on cognitive development. Barona et al. (2017) observe neurobiological deficiencies in infants of mothers with an ED history, manifesting in poor language and motor skills. Such studies that use medical outcomes (biological or neurological markers alike) are crucial inasmuch as they emphasise the risk that mothers' EDs place on the health and growth of infants. However, EDs are considered primarily psychological in their nature (American Psychiatric Association, 2013). As such, ED individuals struggle to hold a nutritional diet and a stable body weight that would prevent medical harm to infants. Therefore, these papers cannot propose a feasible mechanism of change.

Studies geared towards the psychological aspects of EDs have been better able to do so. For example, a study by Hoffman et al. (2014) compared how mothers with and without a history of EDs feed their infants. The paper implied that by teaching mothers more beneficial feeding techniques, infant growth may be ameliorated. Other researchers have also focused on EDs in a similar way; placing attention on mothers' feeding behaviours in relation to the child (e.g., Reba-Harrelson et al., 2010), often by focusing on the relationship between mother and child (e.g., Sadeh-Sharvit, Levy-Shiff, et al., 2016). In another study, Sadeh-Sharvit, Zubery, et al. (2016) tested their parent-based prevention program with twelve intact families with an ED mother. By equally allocating feeding responsibilities to both parents, providing psycho-education to mothers, and improving pertinent communication between parents, the researchers found significant improvements in parents' approach to feeding their children (aged five years or less). These results increase confidence towards breaking the cycle between maternal EDs and similar symptoms developing later on in children's lives. However, that participants consisted of intact families indicates a baseline that was already more supportive of change than may be with single ED mothers (Linville et al., 2012; Stice,

2002). Furthermore, these interventions helped mothers mask their symptoms when treating the child, but did not provide relief for mothers' DE.

As the child grows older and more perceptive, the subtleties of mothers' reactions to food may become apparent and be mirrored (Arroyo et al., 2017; Lowes & Tiggemann, 2003). Therefore, preventing the onset of EDs in children of affected mothers would be more enduring if mothers were provided support as well. Afflicted mothers may experience shame in terms of not viewing themselves as 'good enough mothers' (Tuval-Mashiach et al., 2013), shame of their body and concerns as part of their EDs (Goss & Allan, 2009), and the all-too common shame experienced when struggling with mental health stigma (Clement et al., 2015). These issues unfortunately complicate research endeavours (Harris, 2010). That research tends to focus on the child's health further implies that the woman struggling with DE is not as important as the mother that she is to her child. This, then, may intensify the self-selection bias encountered in these studies, as mothers may fear being perceived as 'bad mothers' (Tardy, 2000).

Focus on the mother: Quantitative Studies

In a society where thinness is idealised (Fitzsimmons-Craft et al., 2012) and yet pregnancy is encouraged, many mothers experience a dissonance (Hodgkinson et al., 2014; Johnson et al., 2004; Lee et al., 2020). The bodily changes linked with pregnancy and becoming a mother generate an additional tension, further stressing the need for an open space for affected mothers to be heard. Knoph et al. (2013), and other researchers, have focused on the pregnant mother, as opposed to the child, giving space for the individual that is the mother. Nonetheless, these studied participants' frequency of ED behaviours during pregnancy and the post-partum period. While mothers were being attended to, this was done in terms of their behaviours and not the concerns (e.g., fear of weight gain) that give rise to those behaviours (Stice, 2002). Another study (Micali et al., 2007) included such concerns as part of their methodology, showing interest in mother's experience of her ED during pregnancy. Nonetheless, this was enquired using dichotomous questions (e.g., "have you had a strong desire to lose weight this pregnancy?"), the Eating Disorder Examination Questionnaire (EDE-Q; Luce & Crowther, 1999) and other self-report measures evaluating frequency of compensatory behaviours. Such closed-ended questions neglect other important experiences of the transition to motherhood and how these interact with DE. Furthermore, the use of quantitative methods in these studies gives rise to inconsistent findings on the course of EDs during the transition to motherhood; with some studies finding alleviation of ED

symptoms, and others finding contradicting evidence (e.g., Baskin et al., 2021; Coker et al., 2013; Watson et al., 2013). Even within these studies, quantitative methods are limited in their ability to clarify the mechanisms behind symptom fluctuation, or the "how". In a study conducted by Crow et al. (2008), for example, restraint over eating, weight and shape concerns reduced during pregnancy by comparison to the pre-partum and post-partum period, but this does not provide explanatory insight to this phenomenon. Pinpointing the mechanisms by which motherhood may improve or aggravate the experience of DE is important in order to better offer psychological therapy for mothers. As such, answering these questions may be achieved through the use of qualitative methodologies, in which women are given the space to interject from their own experiences.

Focus on the mother: Qualitative studies

Pregnancy and post-partum. Tierney et al. (2011) carried out semi-structured interviews with eight mothers, exploring the experiences of pregnancy and early stages of a child's life in terms of mothers' eating 'problems'. The researchers identified participants through the broad definition of "eating disturbance" (akin to DE), in order to overcome barriers reaching ED mothers. This is important as many women have not been formally diagnosed with an ED (Fairburn & Harrison, 2003), yet EDNOS is estimated to be more common than previously speculated (Micali et al., 2013). Tierney et al. (2011) asked participants to discuss their experiences during and following pregnancy in terms of their body, the healthcare they received, feeding their infants, their own DE, and others' approach to their DE. Interviewees discussed the tension between two identities: the 'ED', and the 'mother', such that there was a push-and-pull between prioritising their child and remaining loyal to DE. When motherhood replaced the focus previously given to DE, mothers also described coping better with the aforementioned tension, and were relying less on DE. The study was able to clarify the divergent cases of DE fluctuations during and following pregnancy and the individual nature of its benefit to or hindering of recovery. Despite this, the order of topics participants were asked to discuss (i.e., discussing 'feeding of infants' before mothers' 'personal experiences') may have primed mothers to perceive and therefore describe their experience in terms of its conflict with being a 'good enough mother' (Strack, 1992).

Taborelli et al. (2016) asked mothers only about their experience of pregnancy and mothering, without mentioning its potential effects on infants. Twelve mothers of infants aged between eight months and two years (a time frame believed to allow more access to

reflection on memories of pregnancies in retrospect; Miller, 2005) participated in face-to-face semi-structured interviews. As some participants were not first-time mothers, this allowed for a more wholly reflection of mothering in the context of EDs. This study also voiced a conflict of sacrificing the ED identity for the sake of focusing on mothering. Participants also discussed the bodily changes and weight gain as a direct challenge to their ED, and the struggle of losing weight after birth without aggravating their ED. As such, this study also elucidated the challenges to recovery for mothers suffering from EDs as being a function of becoming a mother. A limitation to this study is that participants were included only if they had received a DSM-IV ED diagnosis during pregnancy, thereby less open to the experience of DE as a general phenomenon. The researchers employed an IPA approach, which acknowledges participants as 'experts in their own experience' (Tuohy et al., 2013). Yet, recruitment was achieved on the basis of having received a diagnosis by another professional, which is then considered the "expert" instead. Thus, the inclusion criterion is discordant with the methodology applied.

Both qualitative studies (i.e., Taborelli et al., 2016; Tierney et al., 2011) focused only on pregnancy and a short period of time following it. Since motherhood progresses beyond these, it may be useful to consider more challenges of motherhood besides those relating directly to pregnancy. This is because, as described elsewhere (Fox & Power, 2009), DE is fuelled by difficulties regulating negative emotions, which may arise from stressful life events. In this vein, various times during motherhood and related challenges (e.g., juggling work) can be experienced as stressful (Slade et al., 2009). As such, it is important to understand mothers' experiences of DE throughout motherhood. Furthermore, as children grow more attentive to their surroundings, mothers may find it harder to carry the burden of secrecy of their DE. This additional shame from their children may add another stressor to the complex cycle of shame in the experience of DE (Goss & Allan, 2009).

Beyond pregnancy and post-partum. Tuval-Mashiach et al. (2013) sampled thirteen mothers of children ranging from seven months to 24 years old. Two study groups were held for 10 meetings of 90 minutes. Each meeting explored a different concern of motherhood and EDs; some topics relating more to children (e.g., mother-child relationship, maternal modelling) and others to mothers themselves (e.g., maternal self-perception). Unlike the previously mentioned studies, the concern of disclosing the ED to the child was discussed as these were mothers of older children. For example, one mother shared that she believed her

10-year-old son knew everything (about her ED), but neither of them would bring it up in conversation. Thus, this study opened an important matter of contention, but left much to be desired regarding how mothers experienced their DE as a result. For example, mothers were not asked to reflect on whether and how hiding DE from their children affected their own experience of DE, or conversely, if sharing with their children relieved negative emotions thereby alleviating a need to engage in DE. This may be due to the group setting, as it is likely that one mother shared her experience without referring to this aspect, priming other mothers to discuss it similarly (Smithson, 2000). In addition, that the group setting was with a psychiatrist or other professional may have limited participants' comfort to disclose their current relation to DE, as mothers may fear professionals' judgements of their fitness to be a mother (Tardy, 2000). An additional limitation is that mothers were identified as a function of being hospitalised for their EDs. As such, it is likely that due to the severity of their mothers' DE, children were already aware of their mothers' ED behaviours, giving rise to similar experiences of 'secrecy' between participating mothers. This, then, limits the breadth of knowledge on the experience of mothers from across the spectrum of DE severity, which would provide a fuller picture of the interplay between DE and mothering. Including participants from either end of the extremes of severity of symptoms might mean that the issues discussed are only common among those particular groups (Barbour, 2001; Roulston & Liljestrom, 2010), and therefore would not be applicable to the entire range of DE mothers.

Stitt and Reupert (2014) conducted one-on-one telephone interviews instead of face-to-face group interviews. Participants were recruited through advertisements in websites and local newspapers, conceivably signifying that the sample consisted of a range of mothers on a spectrum of DE severity. In this study as well, a common theme was the issue of secrecy from children. Despite having a different recruitment method and broader inclusion criteria to the aforementioned study, mothers in this study did not discuss how specific motherhood challenges (such as secrecy) interplayed with their DE either. The experience of mothering and DE was discussed in terms of the relationships held with children and the family, but not in terms of the mother's emotional or psychological experience of her DE.

These studies add to the body of knowledge of the experience of DE in mothers of many ages and stages. However, they do not place attention to potential stressors that may arise from different challenges throughout motherhood, merging "mothering" as a general experience instead. This confines the degree to which future therapy may be tailored specifically to mothers and in accordance with the particular challenges they face. For example, preparing foods that agree with children's preferences may provoke temptation and

ultimately elicit guilt (Lynch, 2009). A different type of trigger may be the maturation of children and the "empty nest" phenomenon (Midlarsky & Nitzburg, 2008), wherein children leave the home. It is possible that these introduce negative emotions that are difficult to regulate, giving rise to reliance on DE. These hypothetical examples illustrate the gap that is yet to be bridged on the experience of mothering and DE. Furthermore, some topics discussed in these studies (e.g., Stitt & Reupert, 2014; Tuval-Mashiach et al., 2013) placed focus on the child. Once again, this may have acted to frame the mind-set of participating mothers to focus on the consequences of their DE on their children's well-being, instead of their own experiences.

As participants in these qualitative studies were not interviewed anonymously, it is possible that mothers who chose to participate were particularly more open to discuss their difficulties. This is important to note since individuals suffering from EDs tend to employ secrecy to conceal symptoms (Pettersen et al., 2008; Vandereycken & Van Humbeeck, 2008). As the pressure of being a 'good enough mother' is added (Tuval-Mashiach et al., 2013), it may well be that some affected mothers are reluctant to disclose their experiences, especially if a study does not include an anonymised procedure. This calls for qualitative research that allows for better anonymity.

Focus on the individual's experience

By focusing on the mother as a person and not just as a mother, research would be showing genuine interest in her experience through qualitative and anonymous research. Furthermore, considering DE rather than a diagnosis of ED changes the perspective such that there is a phenomenological and subjective attention to the suffering of the individual that is irrespective of how it is perceived by another person. Additionally, research with selection criteria of DE as self-reported rather than a diagnosis of EDs may broaden the support that can be offered to mothers. The focus on the individual in qualitative research also may give mothers a space to talk about their DE in a setting where fear of judgment is minimized. Thus, shame and secrecy for these women may be limited, and this may in itself help reduce reliance on DE as emotional regulation, as described earlier.

Epistemological and Methodological Critique

Research on DE in motherhood is predominantly from a realist ontology and a positivist epistemology, and tends to focus on frequencies of symptoms. Methodologies

include correlational analyses, ANOVA tests and t-tests. By and large, such studies produce results that contradict those emerging from other positivistic studies, and even within the same study. This manifests in either a sustained 'improvement' of DE over the course of motherhood for some (especially during pregnancy), a 'relapse' for others (especially during or after the post-partum period), a lack of improvement or even a worsening of symptoms for the remaining individuals. Within the positivist paradigm, some studies have attempted to elucidate these findings by conducting prospective studies rather than retrospective ones, and have aimed to explore the phenomenon further by including mothers struggling from BN as well as those struggling with AN (e.g., Blais et al., 2000).

Most quantitative as well as qualitative studies only include participants meeting diagnostic criteria of an ED (American Psychiatric Association, 2000, 2013). Yet, the transient nature of diagnostic criteria has proven challenging to both prospective and retrospective studies, such that participants' diagnosis upon recruitment would change over the course of the study due to the publication of newer DSM versions. Furthermore, the number of cases that have fluctuated between ED diagnoses, even comparing within the same DSM version, has reached statistical significance to indicate this is more than chance. As such, though studies seek to generalise from the sample to the population, the aforementioned obstacles indicate that such an endeavour is unlikely to be stable or reproducible. Additionally, IPA studies with inclusion criteria of specific ED diagnoses suffer from epistemological lack of coherence in their approach to recruitment. That is, despite IPA's acknowledgement of participants as 'experts in their own experience,' recruitment was based on a professional's 'expert opinion' on the participant's experience. Similarly, other studies have made a-priori decisions to analyse data based on pre-determined stages of motherhood (e.g., early pregnancy, middle to late pregnancy; Taborelli et al., 2016). The decision to label overarching themes in accordance with previous research on motherhood stages (Smith, 1999), as opposed to reflecting experience described by participants, also poses an epistemological tension with researchers' phenomenological and idiosyncratic approach.

These aforementioned criticisms emphasise the need for phenomenological research that coherently embodies phenomenology throughout recruitment and analysis. Though DE is a categorisation of experience, it reflects a critical realist ontology wherein struggles with the body and diet are considered real and often distressing. Yet, it differs from taking on an ED inclusion criterion in that the individual becomes an expert of their experience to decide whether they are suitable to participate.

Context and Methodology

Considering the underpinnings of phenomenology and constructivist epistemology, the context in which we experience the phenomenon itself contributes to our relationship with that phenomenon. A holistic consideration of an experience's context (e.g., geographic, linguistic, sociocultural), as well as the context in which the experience is being recounted (e.g., semi-structured interviews, face-to-face), would deepen idiosyncratic data and its variety in the constructed body of knowledge on the topic of DE in motherhood. Previous research indicates that shame and stigma for mothers struggling with mental health is a barrier to the expansion of research, and more so as shame is generally present among individuals struggling with DE (Swan & Andrews, 2003).

Recruiting participants and collecting data in a more anonymised manner might reduce shame for mothers (Jowett et al., 2011) as well as fear of safeguarding consequences and related ambiguity (Bye et al., 2018). In turn, this would not only expand the database of participating mothers and support generalisability in quantitative studies, but could also provide a less threatening environment to deepen responses in qualitative studies. As such, the context in which the experience of DE in motherhood is recounted might facilitate access to more aspects of this experience (King et al., 2018).

Considering that IPA takes into account the researcher as part of the research's context, a further advantage to accessibility might be when researchers are more familiar with the context in which the phenomenon is being experienced and studied.

The Context of DE in Israel. As the researcher of my study, I acknowledged my Israeli background amongst my cosmopolitan upbringing which exposed me to societal expectations of thinness ideal around multiple Western countries, including Israel. In fact, it is notable that despite the small size of Israel, several of the studies on DE in motherhood referenced in my literature review were conducted in Israel (e.g., Sadeh-Sharvit, Levy-Shiff, et al., 2016; Sadeh-Sharvit, Zubery, et al., 2016; Tuval-Mashiach et al., 2013). Yet, in light of the high rates of DE among women in Israel (Latzer et al., 2008), and that Israel holds the highest rate of new mothers compared to other Western countries (OECD, 2019), the proportion of Israeli studies referenced in my study is put into context. Though the speculation on *why* DE rates are notably high in Israel cannot be explored in depth in this thesis, it is still important and relevant to touch upon the existing theories and research as part of my study's context. Firstly, Israel is a developed first-world country whose citizens are frequent travellers and whose government is in communication with other Western countries' governments (Rebhun & Waxman, 2000). As a technologically advanced nation, Israel participates in internet and

media-based trends (Poushter et al., 2018). As such, the same influences that are pertinent to other Western countries in relation to the societal thinness ideal apply to Israel as well (Katz, 2014). In terms of Israel's unique context, some research has suggested high rates of DE in Israel as part of the generational holocaust trauma effects (Zohar et al., 2007). Other studies have proposed that high DE rates in Israel are found in large proportions among women from Kibbutz communities (i.e., collective communities traditionally based on agriculture; Latzer et al., 2008). This phenomenon could be explained by a different lifestyle and heightened responsibility over food and agricultural economy (Latzer et al., 2008), and/or as an unfortunate consequence to coping with a lack of control around unreported repeated cases of sexual abuse in Kibbutz communities (Shoham, 2009). The aforementioned historical and psychosocial factors (i.e., Holocaust generational trauma and Kibbutz) are important to contextualise DE rates among women in Israel, in addition to its exposure to the Westernised thinness ideal.

The Context of Motherhood in Israel. The Western societal construct of a 'good mother' is contextualised in Israel's religious, political and sociological climate, strengthening this construct into one of a 'strong mother'. Sinai-Glazer and Peled (2017) described the Western social construct of the motherhood myth as the expectation of mothers to provide unconditional maternal love, to experience mothering as instinctive and natural, to be entirely responsible for the welfare of the child and to blame for children's deficiencies, and to be totally devoted to motherhood. The authors described the Israeli context to strengthen motherhood expectations due to societal values regarding family, Jewish religion and tradition, and further the importance of family as a 'safe haven' in a country with unstable national security. The latter is perhaps most crucial in considering the 'strong' connotation to the construct idealised in Israel, especially as many Israeli mothers have previously been soldiers in the Israel Defence Forces (IDF), and yet are most likely to be the primary caregiver for children when some Israeli fathers are called upon for reserve duty in times of war.

I considered that my being familiar with the Israeli culture and language may be beneficial in knowing how to approach recruitment and data collection. This is particularly essential considering CoP's call for research to be inclusive and diverse. Though the phenomenon of DE as a re-emerging experience in motherhood has been observed globally, and with notably high rates in Israel (Latzer et al., 2008; Shloim et al., 2014), qualitative research has yet to shed light onto the experiences of those mothers. Such research is important not only to expand the body of knowledge such that it is inclusive, but also to

identify further the idiosyncratic, societal, and cross-cultural aspects that can further guide the support that is offered on an individual as well as societal level. Therefore, I argue the importance of conducting IPA with Israeli mothers, and for interviews to be conducted in participants' native language (i.e., Hebrew). Though the translation of interviews into English introduces an epistemological tension in that it moves away from portraying participants' experiences in their own words (Van Nes et al., 2010), this endeavour provides a starting point to voice Israeli mothers' experiences. Further considerations on the translation process in IPA methodology and its relation to epistemology are discussed in the 'Methodological Changes and Reflexivity' section.

Implications of the Review and Research Gap

Much remains to be understood in terms of the subjective experience of re-emerging DE in motherhood. Specifically, understanding how women make sense of the interaction between motherhood and DE could clarify fluctuations found in the literature. Thus, CoP practices would be better fitted to mothers' experience both as mothers and as individuals struggling with DE.

Furthermore, in order to reach mothers highly ashamed of their DE, qualitative research would benefit from employing anonymous platforms for recruitment and data collection, such as synchronous online chatting or anonymous telephone interviews.

Additionally, in order to reach a wider portion of the relevant population, recruitment would benefit from the inclusion of DE (rather than a narrow focus on EDs), since many women experience ambiguity regarding their problems and fluctuate in type and severity.

Moreover, the lack of research outside of English-speaking populations, and specifically for the topic of DE in motherhood which is common elsewhere, calls for research to be inclusive of other languages and cultures. Considering reflexivity and the positioning of the researcher in IPA, my familiarity with Israeli culture and the Hebrew language provides me with an opportunity to explore Israeli mothers' experience of re-emerging DE.

In conclusion, the topic of mothering and DE is yet to be understood in terms of the interplay of mothering experiences with the re-emergence of DE, and for mothers around the world that might be experiencing shame as an obstacle to seek support.

Rationale for the Study

Some mothers with a previous history of DE find themselves struggling with re-surfacing DE during motherhood (including pregnancy, the post-partum period, and early motherhood). The literature suggests that emergence of DE may relate to meaning-making processes of external and internal events (e.g., a loss of a sense of control, emotional regulation).

Considering that mothers experiencing mental health difficulties face societal stigma, and are often reluctant to seek professional support, gaining an in-depth understanding of their subjective experiences may inform therapeutic practices targeted at providing appropriate support.

The rationale for IPA relates to the literature gap about DE in motherhood regarding three aspects: anonymous recruitment and data collection, a focus on subjective experience of distress (i.e., DE rather than EDs), and a focus on the mother's experience of DE as an individual.

Research Aims

The primary aim of my research was to examine experience of a re-emergence of DE in the context of motherhood, and to understand the meaning that mothers make of motherhood in relation to DE.

Additionally, my study aimed to deepen understanding of re-emerging DE in the context of motherhood, and to add experiences from Israeli mothers to contribute to a diverse body of knowledge. Another aim related to the use of anonymised recruitment and data collection methods that allow for more approachability.

Taken together, this research aimed to contribute to existent literature and address gaps through methodological and epistemological coherence which hones in on subjective experience whilst considering context in the process of meaning-making.

Research Question

What is the lived experience of re-emerging DE in the context of motherhood?

Methodology

Chapter Overview

I outline my study's methodology, providing a rationale for my decisions. I relate methodological choices to underlying philosophical stances of ontology and epistemology, and my relative positioning. I outline the process of the methodology applied, whilst considering validation of quality in research.

Ontological and Epistemological Positioning

Generally speaking, research sets out to discover or understand a phenomenon. The specific field of study, research question, and methodology are largely informed by underlying ontological and epistemological stances. These are closely related; ontology seeks to know *what* is real, and epistemology questions *how* we know what is real (Willig, 2013b). A researcher's belief about the concreteness of reality would inform how to explore that reality or the *experience* of it. Therefore, epistemology tends to inform and be reflected by methodology.

As a critical realist, I regard the concepts of DE and motherhood as real, but assume these to be experienced differently. I am a 'constructivist', in my belief that the experience of these is influenced by individual views and previous experience. I believe that sociocultural factors mediate the experience of DE during motherhood, including aforementioned stigma. Though distinctions between ontological and epistemological positions vary, this would indicate a critical realist ontology and a constructivist epistemology. My approach to these positions could be described as phenomenological (Cal & Tehmarn, 2016; Drummond & Heidegger, 2007), as I believe individuals 'construct' their knowledge *through* subjective experience. My interest in individual experience of re-emergence of DE as an exploration to illuminate the literature gap reflects my phenomenological positioning. In this way, qualitative methodologies could provide insight into existing quantitative findings on fluctuations in DE in mothers, reflecting my support of pluralistic research. Beyond a quest for insight into conflicting findings, the choice for qualitative methodology relates to CoP humanistic values and a focus on exploring and voicing individual accounts (Woolfe et al., 2010). The in-depth and open questioning that qualitative methodologies employ also enables investigating previously unexplored areas of the topic (Galletta, 2013; Willig, 2013a).

Rationale for Using IPA

Multiple qualitative methodologies have been used in the field of CoP, including but not limited to Thematic Analysis (TA), Interpretative Phenomenological Analysis (IPA), Grounded Theory (GT), Narrative Analysis (NA), and Discourse Analysis (DA). Though a discussion of each methodology is beyond the scope of this thesis, in this section I discuss how my positioning and the gap in the research on DE in motherhood led me to choose IPA.

To reiterate, the literature review pointed to a gap in our understanding of how mothers make sense of re-emerging DE in the context of motherhood. This is in light of contradictory findings that: some mothers experience an alleviation in DE during pregnancy that is sustained in the post-partum period; other mothers report that such alleviation is short-lived; and yet another group of mothers have experienced a lack of improvement altogether. Understanding mothers' subjective experience of re-emergence of DE could help elucidate these contradictions. Existing literature therefore points to a gap that could be filled using a phenomenological approach. Considering the stigma as a barrier to explore mental health struggles among mothers, and the aforementioned limitations of using ED diagnostic criteria, a rationale for phenomenological research is strengthened. I suggested that the existing gap would benefit from exploration with a subjective inclusion based on DE, and for qualitative anonymous methodologies to reduce shame in the research setting. In line with constructivism and critical realism, and a phenomenological approach, the most suitable methodology for this topic and gap was deemed to be IPA.

As I believe that DE is a reality that can be directly discussed, methodologies originating from social constructionist epistemologies were not considered suitable. Having a critical *realist* ontology and a constructivist epistemology has rendered the following methodologies inappropriate: DA, and NA/TA from a social constructionist perspective. These do not align with my constructivist epistemology and phenomenological approach wherein experiences are shaped by individual meaning-making. Whilst this meaning-making process may be impacted by societal factors and language, I nonetheless assume that the meaning individuals make can be accessed, and can be regarded as their own subjective experience (whether or not it was impacted by language and social constructions).

Whilst GT was considered for the potential of answering the question "what are the psychological processes that give rise to the re-emergence of DE during motherhood?", theories about the phenomena already exist (e.g., emotional regulation, lack of control,

identity struggles). Additionally, the question "*what are the processes…"* is incongruent with my *critical* realist ontology as it assumes that there is a discoverable reality, regardless of subjectivity and context. The identified gap in literature may reflect the lack of interest in the subjective experience of DE among mothers, potentially paralleling the stigma around this topic. I believe that analyses emanating from realist positions might limit innovative understandings to result from the study, as the analyses would neglect subjectivity in order to produce 'generalisable' findings.

TA was considered due to it sharing with IPA the foundations of identifying themes and the ability to be used with critical realist underpinnings. I considered IPA to be more approachable in terms of guidelines for analysis and very well aligned with my epistemological approach. Furthermore, the research gap indicated the importance of proliferating through in-depth accounts of mothers struggling with DE with an emphasis on subjectivity as stepping away from embodying stigma in the research. Therefore, the subjective and in-depth nature of IPA was deemed to be better placed than TA to this end.

In conclusion, my study sought to explore mothers' experience of the re-emergence of DE during motherhood. My ontological/epistemological positions of critical realism/constructivism and the phenomenological nature of my question led me to choose IPA.

Overview of IPA and Rationale for Choosing this Methodology

IPA seeks to explore, through semi-structured interviews, individual's meaning-making of lived experiences. Depending on epistemology and the research question, IPA can include contexts (e.g., societal, linguistic, cultural) that contribute to meaning-making. As the approach emphasises subjective experience of phenomena, data emerges from participants' interviews, rather than pre-determined hypotheses. I chose IPA as my methodology, and I will describe its components and theoretical bases in what follows.

Theoretical foundations of IPA

IPA values individual lived experience of phenomena, where interpretation of a phenomenon gives rise to its meaning made and therefore its subjective experience. It is important to consider the underlying foundations to the IPA approach: phenomenology, hermeneutics, and ideography.

Phenomenology. As initially proposed by Husserl, phenomenology seeks to reflect on experience in a rich and meaningful way, such that one 'takes a step back' from the phenomenon to examine how it is subjectively experienced. Phenomenological research studies people's experience of a particular phenomenon, through 'systematic' and 'attentive' reflection on subjective experience (Costantino, 2012). One is asked to reflect on an experience and describe its essence or subjective meaning. In this dialogue between researcher and participant, the depiction of the phenomenon is allegedly situated within its sociocultural context, and the research setting wherein the phenomenon is being explored.

Therefore, phenomenological research suits constructivist epistemology, and critical realist ontology, wherein an objective 'phenomenon' is believed to exist but experienced subjectively, and that meaning-making processes construct how the phenomenon is experienced. Through the back-and-forth between researcher and participant, both gain insight and construct knowledge about the phenomenon of interest.

Husserl posited that one must bracket their assumptions about a phenomenon in order to investigate the essence of an objectively described and "universal" experience (Langdridge, 2007). However, later iterations by Heidegger, Merleau-Ponty and Sartre (Macann, 1993), have emphasised that it is never possible to 'bracket' oneself, as the process of reflection takes place by the individual in those contexts. Similarly, many philosophers have argued that the same phenomenon will not be experienced identically every time it is reflected upon, even by the same individual, as context will change the description and meaning of a lived experience. As such, phenomenological philosophy as used in IPA takes into consideration the subjectivity and context of the individual that form part of the experience. This gives rise to the concept of interpretation in phenomenology, and thus relates to the second basis of IPA, hermeneutics.

Hermeneutics. Central to IPA is the concept of 'interpretation', and hermeneutics is essentially the theory of interpretation. Accordingly, the researcher is actively interpreting the data, which is understood to be a complex composition of the researcher's own previous experiences that come into play with the data itself. In IPA, researchers engage in a 'hermeneutic circle' which comprises of repeated immersion in data and annotation of researchers' interpretation, in terms of how small units of meaning (e.g., words) relate to the whole unit of meaning (i.e., the overall essence).

The hermeneutic circle also refers to the engagement between researcher and participant which gives rise to the context in which experience is described. Similarly, it considers the

researcher's interpretation as inextricably bound to the researcher's 'background' for interpreting through their own lens. The researcher is therefore required to engage in a repeated process of interpretation of data. Of course, interpretation is part of the participant's recounting of experience as well, resulting in a 'double hermeneutics' wherein the researcher is making sense of the sense made by participants. This process is akin to the adjusting of a lens in a camera; to view the part and the whole in order to produce a coherent interpretation by the researcher.

Ideography. At the heart of IPA is the concept of individual and subjective experience. As context is believed to play a part in interpretation, IPA acknowledges the uniqueness of experience for each participant. As such, IPA requires the researcher to analyse each participant's experience before attempting to compare between participants. That is, the process of analysis of identifying similarities and differences between cases is only to be done once each account is interpreted in its own right. This detailed focus on the individual narrative results in an analysis that reflects patterns of meaning across cases while capturing idiosyncratic nuances.

Characteristics of IPA

I will now describe three characteristics of IPA which are important to consider in my research; epistemological basis, focus on context, and the role of language. These relate closely to my rationale in using IPA.

Epistemological basis. While IPA is suitable to many positions, it is closely matched with a critical realist ontology and phenomenological constructivist epistemology. Ontologically, IPA falls within the boundaries of critical realism as it tries to analyse a phenomenon which is believed to exist objectively, but which is experienced subjectively. Epistemologically, IPA reflects constructivism in a phenomenological way as it assumes that knowledge is constructed through subjective interaction with an objective reality, and that multiple facets of context interplay (e.g., sociocultural, relational, personal history). As such, it assumes that there is an intersubjective process of meaning-making, therefore reflecting a phenomenological basis. This is also reflected in the analytical process of hermeneutics.

Focus on context. IPA considers the interview's context as giving rise to conveyance of experience, therefore that researchers themselves (unintentionally) impact the delivery of experience in the interview. Of course, part of this focus on context means that the researcher needs to be aware of participants' context (i.e., sociocultural, linguistic, or otherwise) and to consider how these contribute to the essence conveyed whilst staying true to the underlying 'melody' (i.e., content; Shinebourne, 2011). The same is assumed regarding the researcher's context; emphasising importance on reflexivity and an awareness of multifaceted contexts of the participant, researcher, and the interaction in between.

The role of language. Phenomenological research is primarily interested in the content of the data and how the participant's account sheds light on the phenomenon of interest. Yet, IPA does not seek to separate the subjectivity of an individual from the experience that they are reporting. The role of language thence is primarily 'expressive' as a medium of transmitting information from participant to researcher (Willig, 2012). Nonetheless, IPA pays attention to word choice, syntax, and intonation in terms of meanings invoked, as well as emotional and psychological states that can be interpreted from these. As a constructivist phenomenological researcher, I focus on language in terms of the meanings invoked in Hebrew, and translation choices to capture my understanding of participants' accounts.

Methodological Changes and Reflexivity

I originally sought to collect data with mothers in the UK through anonymous synchronous online chat. The rationale for such anonymous data collection related to the extent to which mental health is stigmatised in mothers, and the difficulty in sharing experiences openly when safeguarding concerns are at the forefront of one's mind. Through the mediums I tried to recruit for this type of data collection (e.g., Mumsnet), I received responses from relevant mothers saying they did not have the time. There were also three occasions in which interviews were set up, however, due to their anonymous nature, there was no way for me to follow up with mothers when they did not log-in. I also noticed my distance from the culture I was in, and how potentially my recruitment attempts were more in line with my experience as a research assistant in Israel. I wondered whether my communication of recruitment was somewhat like a 'fish out of water' as an Israeli in the UK, and if perhaps it was going to be difficult for me to bridge a gap which I could not fathom. In realising this, I also considered how a bulk of my literature review was actually

based on studies conducted in Israel, as the rates of EDs are considerably high in Israel (Latzer et al., 2008) as well as high rates of new mothers (Donath, 2015). Additionally, being familiar with the Israeli culture and the narrative of a 'strong mother' (Sinai-Glazer & Peled, 2017), I considered how the context may present an opportunity to explore the phenomenon of interest. Therefore, not only would I be at an advantage of knowing how to communicate my recruitment attempts, but I would be better able to contextualise participants' narratives.

Furthermore, when thinking about relevance to CoP, it came to my attention that practices in the UK, the United States, and other English-speaking countries tended to be informed by research conducted in English. In a world where diversity and international relations are more and more common, it is important to be informed by a wide array of cultures, and to conduct research in different languages. Such qualitative research can then be accumulated and parallels as well as differences can be drawn to understand which kinds of questions or concerns to consider when working with mothers struggling with a re-emergence of DE, no matter where she is from, as well as specifically considering her background. Furthermore, the division of CoP in the UK lists the importance of attention to diversity and difference (The British Psychological Society, 2017b). By conducting research on a topic that is prevalent across multiple countries, notably reported more in Western countries (including Israel), practitioners will be more equipped to work with many mothers. This means that a larger proportion of women can be treated appropriately, and in doing so a prevention of worsening of conditions, as well as the transmitting of such difficulties to children, can be promoted.

As with any IPA study, there is a tension between balancing the idiographic nature and subjectivity of each participant's account, whilst finding patterns in the whole sample. Therefore, I do not claim to infer from the sample to a population. However, the in-depth understanding of the phenomenon for a few mothers can be transferrable to future research and practice in shedding a light on which subjective aspects can be expected to emerge differently for future research participants or for practitioner's clients.

Once I began recruiting in Israel, I gave mothers the option of either online synchronous chat or through Skype audio chat, as well as the option of conducting the interview in English or Hebrew. All mothers opted for Skype chat and to discuss their experience in Hebrew. While I have noted here the importance of widening research in multiple languages, and the importance of considering how translation is an act of interpretation, the relationship between language and how we experience the world is beyond

the scope of my thesis, and the lens through which I am viewing it in my epistemological stance.

Procedure

Ethics

Ethical approval was granted by the Research Ethics Committee of UEL to conduct interviews in English or Hebrew with mothers in the UK and in Israel (Appendix A). An invitation letter was posted in social media, and given to each interested participant (Appendix B). The letter included my details, the nature of the project, the extent of participation, confidentiality, the participant's right to withdraw and to contact the researcher and supervisor. A consent form was given asking participants to confirm having read and understood the information sheet (Appendix C).

Audio recorded material was password-protected and encrypted. Virtually signed consent forms were kept on Qualtrics, ensuring security and data protection. Consent forms did not include participant's names, further guaranteeing security and confidentiality. Only I had access to participants' first names, for the purposes of communication to arrange interviews. During transcription and translation, confidentiality was immediately secured by providing pseudonyms. Ethical approval was granted for chat-based interviews over Skype as well as over telephone.

Reflections in research supervision led me to conduct solely Hebrew interviews, both to maintain homogeneity of experience and to reflect my stance on how language relates to experience.

Sampling Method

I used purposive sampling wherein the inclusion and exclusion criteria produce a sample suitable to the IPA research question (Pietkiewicz & Smith, 2014). The process of narrowing a sample that was homogenous enough to reflect a similar experience, yet refraining from pre-determining a *subjective* experience, led me to define DE as a self-reported experience of distress from pre-occupation with diet, weight, body shape and/or body size. Through research supervision, I deliberated that using an outcome measure as an entry threshold (such as the EDE-Q; Fairburn & Beglin, 1994) would contradict my epistemological position. I maintained that participants know whether they have struggled with this topic and it is their self-selection that indicated suitability. Motherhood was defined as having given birth to and

parenting at least one child, for the sake of homogeneity and due to the relevance of bodily changes associated with motherhood and DE. In order to give an opportunity for a variety of motherhood experiences (i.e., pregnancy, post-partum, and beyond) to be discussed in relation to DE and meaning made of motherhood, I recruited biological mothers of at least one child that was at least 8 months old. Considering average ages of new mothers in Israel (OECD, 2019), and average ages of struggles with DE (Reba-Harrelson et al., 2009; Tiggemann & Lynch, 2001), age range was set to 20-48. In order to allow for reflection on differences in the experience of DE in motherhood compared to other periods in life, participants were included if they experienced DE before pregnancy as well as a re-emergence of DE during motherhood (i.e., pregnancy and/or onwards).

Participants were included if they were biological mothers for at least eight months, aged between 20-48, experienced DE before motherhood and again during motherhood. Importantly, recruited mothers were those who considered the role of motherhood in the re-emergence of their DE.

Sample Size

In accordance with suggestions for IPA within a professional doctorate to recruit six to eight participants, I recruited seven participants. This is in line with IPA's idiographic nature, and therefore requires richness of each interview (Pietkiewicz & Smith, 2014). A sample of seven was deemed suitable for sufficient richness in exploring my research question, and small enough to avoid losing sight of idiosyncrasy of interviews (Braun & Clarke, 2013).

Recruitment

A recruitment leaflet including details of the study (Appendix D) was posted anonymously by asking colleagues, friends and family to post on their social media pages or to appropriate individuals/groups. Snowballing also resulted in recruitment as some participants made contact with other mothers.

Interested participants were given a link to a Qualtrics survey (Appendix E) which filtered their suitability. This link also included the participant information sheet and consent form. Participants were asked to provide a telephone number or e-mail address so that I may contact them to arrange a suitable time, and through their preferred medium to be interviewed (i.e., telephone or online chat). This also provided me the opportunity to clarify any unclear or missing information on the Qualtrics survey.

No individuals asked to withdraw from the study. One interested participant was deemed unsuitable due to subjectively reporting the re-emergence of DE during her motherhood as unrelated to her motherhood.

Two participants were interviewed in English prior to my informed decision to analyse only Hebrew interviews. Those two interviews took place prior to any Hebrew interviews, and thus formed part of the pilot experience, alongside another pilot Hebrew interview. My interview schedule was well-informed by two languages and by UK and Israel nationals with relevant experience of re-emerging DE in motherhood.

Due to the anonymity I was striving for, all interviews were carried out over audio conversation on Skype and all were audio recorded. Though participants were given the choice between audio-based Skype interview or synchronised live chat interviews, all opted for audio-based interviews. The interviews lasted between 47 and 75 minutes.

The Participants

Seven participants were included, and their demographics are presented below (Table 1). For the purposes of anonymity, participants were given pseudonyms, and any potentially identifying information in the transcripts was changed (e.g., children's names). All participants identified themselves as mothers of at least one child (at least eight months old), who experienced DE before motherhood and a re-emergence during motherhood. Mothers were between the ages of 24-47 and had one to four children. Two participants experienced divorce/separation during motherhood, but indicated that re-emergence of DE was not primarily related to the change in marital status, and identified its relation to motherhood itself.

I believe that my sample of seven participants reflected variability of presentation and experience and enabled depth of each unique experience of the meaning of re-emerging DE during motherhood.

Table 1

Demographics of participants.

Participant	Age	Number of children	Age group of youngest child	Age group of oldest child	Marital status
Hazel	35	3	School-aged	School-aged	Married
Ivy	47	4	School-aged	Young adult	Divorced
Juniper	34	1	Preschooler	-	Married
Poppy	31	1	Infant	-	Separated
Sage	24	3[a]	Toddler	Preschooler	Married
Sakura	28	2	Toddler	Preschooler	Married
Yasmin	38	3	Infant	School-aged	Married

Notes. Age group of children: infant (4 weeks – 1 year), toddler (12 months – 24 months), preschooler (2 – 5 years), school-aged (6 – 12 years), adolescent (13 – 19 years), young adult (20 – 25 years).

[a]This participant had 3 children over 2 births; a pair of twins and a subsequent child

Data Collection

Semi-structured interviews were used as they are believed to be well-balanced between being informative and succinct to the question posed whilst providing rich accounts and nuances of individual experience (Smith & Osborn, 2004). In order to be guided by participants' experience, questions in my interview were open-ended and non-directive. Prior to commencing the interview, I told participants to respond to questions in terms of what comes up for them, and encouraged them as experts of their own experience.

Interview schedule. The interview schedule is included in English (Appendix F) and its translation in Hebrew (Appendix G). It was composed following suggestions by Smith et al. (2012), and revised during research supervision. The interview schedule was followed roughly in order to provide a comfortable and organic environment. Questions tended to flow from participants' responses. As such, the interview schedule was a guide but did not dictate the interview to the detriment of the researcher-participant relationship that facilitated a meaningful and individualised discussion of experience (Adams, 2015; Cachia & Millward, 2011). The interview schedule was designed to first ask questions that were deemed less emotionally intensive, in order to ease in. This included the question 'what kinds of feelings/thoughts do you associate with being a mother?', which was then followed-up with

the prompt ‘tell me about your experience of being a mother and what kind of challenges you’ve experienced’ to deepen the discussion of motherhood and to convey a non-stigmatising attitude. The main questions that related most to the research question were posed in different formats such as ‘what do you understand about the re-occurrence of DE during your motherhood?’ If participants described challenges during motherhood, they were asked ‘how have you experienced your DE in challenging times during motherhood?’ followed by ‘what sense do you make of the presence of your DE in these times?’ In order to deepen the discussion of meaning associated with DE and motherhood, some questions were optionally used such as ‘what are the differences/similarities between the DE you experienced in the past and the DE you experienced during motherhood?’ I asked participants ‘how do you feel about having experienced DE as a mother?’ and ‘how have these feelings impacted your DE?’ to further explore the relationship between DE and motherhood. Lastly, participants were asked whether there was anything else they wanted to discuss.

Pilot interview. After developing the interview schedule, I asked an acquaintance (who had experienced re-emerging DE in motherhood) to practice the interview so that I could identify any unclear questions or any obstacles to obtaining appropriate data. Due to my change of language after having conducted two English interviews, I also used those two interviews as retrospective pilots. I noted all my reflections in the reflexive journal.

Conducting the interviews. Interviews were carried out between May 2019 and January 2020 via Skype. Due to mothers’ responsibilities and lifestyle, some interviews were re-scheduled. It was important that I remain flexible and understanding, as these were reflections of the challenges and a depiction of participants’ lifestyles. Similarly, though participants were asked to conduct the interview in privacy, I could hear some participants’ children or babies cooing or interrupting their mothers in the interview. When this occurred, I asked participants if they thought they had enough privacy to comfortably answer questions. This helped open a discussion on how they felt about their children being exposed to their own DE, which related to the interview schedule. Participants were invited to ask any questions prior to commencing the interview, and were reminded that the interview would be recorded. Confidentiality and the right to withdraw were repeated in the interview as well (at the onset and the end). As mentioned previously, the interview schedule was present to

remind me of the topics that I wanted to cover, but it was not followed strictly. It was important that I kept a reflexive journal on paths I took in guiding interviews. In the conclusion of interviews, all topics were covered. I remained attentive to emotional undertones invoked by word choices and tone of voice, in order to remain sensitive to the intensity of the interview experience so that I may check-in on whether they felt comfortable to continue. Despite my worries that I would feel confused as to how to maintain a researcher attitude whilst still being sensitive to participants' emotions (and without then resorting to a more counselling position similar to my other roles in training), I found that this balance came intuitively and I believe that having the interview schedule at hand contributed to feeling grounded and focused. At the end of the interview, participants were sent the debrief letter (Appendix H) over e-mail or text and I verbally described it during our call. Contact details of relevant Israeli organisations were provided, should they require psychological support.

Data Preparation

Data was prepared according to guidelines by Smith and Shinebourne (2012). Audio-recorded material was transcribed manually by using Microsoft Word, and the encrypted password-protected audio recordings were played using QuickTime Player. Transcription, translation, encryption and safe storage of audio-recording was done on my laptop, operating Mac OS. Demographics and survey responses were kept on my data-protected student account on Qualtrics. All transcripts and their translations were repeatedly checked against the original recording to ensure accuracy. During transcription and translation, notes were made of silences, changes in tone of voice, and any utterances (Smith & Shinebourne, 2012). In order to stay true to the context of culture and the Hebrew language (Temple & Koterba, 2009; Temple & Young, 2004), I kept notes of language-specific terms and translated as closely as possible to be understandable to the English speaker yet to capture nuances of each interview.

Analytic Process

In this section, I summarise the steps involved in the IPA I immersed myself in, the results of which are presented in the following chapter. This is offered as a transparent illustration of my work to help assess its rigour.

Analytic strategy and procedure. The collected data were analysed using IPA following Smith's guidelines on the step-by-step process (Smith & Shinebourne, 2012) in order to ensure accuracy, especially as this was my first time conducting IPA. In order to help me get intimate with this methodology and in alignment with my epistemology, I reminded myself that my thinking process and meaning-making is part-and-parcel with the interpretative type of phenomenological analysis. Before every reading, I engaged in a 'grounding' activity where I reminded myself of my research question, epistemology, and reconnected to the essence of the interview. Practically, I created a OneNote notebook for the study, wherein each participant had a sub-notebook. In the following, I describe how some stages formed different columns within the table of my IPA analysis.

Stage 1: Reading and re-reading. I entered this stage by plunging into the data, reading and re-reading the translated transcript as well as its original version, alongside repeated listening to audio-recordings. I noted any reflections on translated material and use of language to reflect upon later. Listening to the original Hebrew recording brought forth to my memory the nuances of emotion and meaning invoked by particular word-choices, use of syntax, and other utterances. Re-listening to interviews helped surround me with the essence of individual context, which provided another layer of depth to my analysis. For example, when one of my participants responded to my question partially by speaking to her infant that had just awoken, I got a glimpse of the participant's worries regarding 'contagion' of her DE onto her infant. This was gently followed with exploration of experiences of concealment (or lack thereof) of DE from her children, and emotions that accompany. These formed parts of my interpretations later. I was feeling excited and eager to analyse each interview, and I was aware of the theoretical frameworks (e.g., emotional regulation, loss of control) through which I conducted the literature review and that contributed to my research question. I engaged in reflexive exercises by discussing with my colleague the epistemological purpose of reading and re-reading. My own epistemological positioning indicated that this helps immersing in the data and observing how different days affect my thinking processes, therefore providing a base for the experience of analysis, and thus was important to note in the reflexive journal. Furthermore, it was helpful for me to realise, as was written by Smith (2009) and Willig (2013c), that once you know the process, "follow it in the way that seems most closely in touch with the participant's account and your understanding of it".

Stage 2: Initial noting. I created a new column on OneNote titled 'exploratory comments' as suggested (Smith & Shinebourne, 2012). I approached this process with an open-mind, aware of my theoretical framework but immersed in the participant's account. I made exploratory comments on the meanings I understood were invoked by participants' use of language. I followed Smith's approach of three layers of interpretation: descriptive comments reflecting the content of what the participant said (in normal font); linguistic comments on the use of language and cultural context (in italicised font); conceptual comments on deeper psychological and discourse-related notes (in underlined font). I noticed that some comments related to my biases and/or state of mind while engaging with the data, and so marked those notes in bold font to form part of my reflexive journal. I perceived an epistemological tension when considering that interpretations are not entirely grounded in participant's words, rather reflect some remoulding. In other words, that I am not representing participants' voices, and moving away from a phenomenological stance. By returning to the philosophy behind IPA (Heidegger et al., 1962; Smith & Osborn, 2004), I reminded myself that the self is included in the analysis, as I affected the research question, the interview schedule, the interview, and thus, the analysis as well. In this reflexive exploratory work, my interpretations arose as responses to participants' use of language to capture the essence of their experience, and therefore it was important to trust myself in the process of making sense of the sense made by participants.

Stage 3: Developing emergent themes. In this phase, I summarised the exploratory comments noted previously. I created another column to the right side of 'exploratory comments' wherein I tried to describe in fewer details the sense I made in my exploratory comments. Naturally, this process of 'labelling' the meaning in fewer words, to resemble short phrases, involved relying on psychological frameworks that were aimed to harmonise between the meaning invoked by participants' accounts and my own interpretations. In this process, the more salient aspects of experience became clearer as these became more organic to describe the psychological meaning of the experience described by participants. That is, more marginal exploratory comments were then more obviously sifted through. This process involved a 'chunking' of exploratory comments based on units of meaning. This chunking summarises the descriptive and interpretative levels of exploratory comments in a coherent manner. I include an example of this phase of analysis in Appendix I.

Stage 4: Searching for connections among emergent themes. Once all emergent themes had been noted, the next phase was to look for overarching patterns among these and group them further. This process was done for each participant separately. I created a Microsoft Word document with a list of the emergent themes, and alongside it another blank document. I began dragging emergent themes into the blank document based on their similarity. As mentioned by Smith et al. (2009), by eye-balling the emergent themes and moving them around, one begins to see how some 'magnet' together. In the process of identifying similarities, I relied on 'abstraction', 'subsumption', 'numeration' and 'function'. Abstraction is the form of identifying patterns based on similarity that can be clustered with a super-ordinate title. Subsumption clusters based on 'like and like' as well, but one emergent theme takes on the 'parent' role for other emergent themes. Numeration refers to the frequency with which a theme is brought up in a participant's narrative; whilst this is not the only indicator of its importance, I found that for some participants more regularly occurring clusters of themes were indicative of their importance of belonging to their own cluster. The process of clustering themes based on their function was especially useful in my process of making connections for most participants. For example, some participants spoke about the same aspect of their experience (such as pregnancy) as both 'good' and 'bad' in terms of how it related to their DE. As such, grouping them based on function (e.g., 'control', 'identity and loss', 'motherhood as motivator') sometimes made more sense than in terms of what is in common to that narrative (e.g., 'meaning of the body'). I labelled each major theme following these ways of identifying patterns, and kept the list of emergent themes underneath (though this was often lengthy) to understand my thinking process which became handy in Stage 6. Additionally, I colour-coded the major themes for each participant, such that I then highlighted the transcript accordingly.

Stage 5: Moving to the next case. The next phase was to repeat the same processes above for the next participant. In order to move on from one participant's account to the next, it is important to try to put aside interpretations and themes that emerged in the previous case. This is in line with IPA's idiographic commitment of data emerging from individual cases (Smith et al., 2009). In order to control for a 'spill-over' effect from previous analyses, I kept a reflexive journal of what themes stuck with me and could contribute to my filtering the next account. Once aware of these, I was better able to separate them from interpretations of the next interview, thus allowing for themes to emerge from each account.

Stage 6: Looking for patterns across cases. The next phase was to assimilate and identify patterns in the emerging themes of the individual analyses to unify analysis. In a blank Word document, I wrote the list of major themes from the first participant, noting alongside it which participant had that theme. I looked at the next participant's major themes and its sub-themes and identified resemblance (or lack thereof) to the previous participant's themes. If I found a pattern in a theme's essence, I would adjust its label to describe that pattern. Again, I would note next to it which participant's interviews contributed to that theme. This process kept going, adding new themes as I went. At the end of this process I had 14 major themes. I wrote each one dispersed on a sheet of paper, and using colours assimilated them based on their essence, resulting in three super-ordinate themes consisting of three to four sub-ordinate themes each. Creating a table cross-referencing each theme with participants' extracts helped keep track of each participant's contribution to the theme. I also used special characters to indicate cases where participants' accounts were included in a theme due to being different in that regard. These processes helped ensure the rigour of my analysis as well as an idiographic approach.

Analysis and Reflexivity

During data collection, I observed that most topics were naturally brought up by participants. This may indicate that my interview schedule reflected aspects of the phenomenon that were salient to mothers when thinking about the re-emergence of DE. The exception was the topic of how participants felt about having experienced DE in motherhood. My understanding of this is that this topic is slightly more profound and multi-layered, perhaps not being as obvious in mothers' minds as an option to explore. Furthermore, as discussed in my literature review, I believe that the experience of shame and stigma around the topic of mental health in motherhood may pose a barrier to the willingness to discuss this openly and with ease. However, to conclude about the reason behind this occurrence is beyond the scope of this study and contradicts its phenomenological nature.

My reflexive journal also included reflections on my experience of the relationship with the participant and any biases or assumptions I may have approached each interview with. I reflected on how my interview style and construction of meaning contributed to the co-construction of meaning in the interview as well as during transcription and translation. That is, aspects which may have impacted my choices of when to introduce a written pause and which words to use as translations of one another from English to Hebrew. Such

reflexivity helped me be intentional about my decisions so that the rigour of my research could be examined deeply. This kind of methodological reflexivity is encouraged by Kasket (2013) in order to be critical about how epistemological, societal, and personal positionings contribute to the development of the research question, as well as preparation and interpretation of data. For example, I was aware that my being on an ED placement during some of the interviews made certain theoretical frameworks more salient in my mind (e.g., emotional regulation) and that I was thinking in a dialectical manner (i.e., 'ED voice' vs 'healthy voice'). Such discourse was moving me away from a more phenomenological approach of being attuned to the meanings invoked and expressed through participants' accounts. Noticing how my language may or may not be guided by personal experience helped me remain intentional and responsible for my interaction with data.

Appraising Quality in Qualitative Research

It is commonly agreed to use Yardley's (2017) four criteria which apply to the appraisal of quality in qualitative research: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. Sensitivity to context refers to the awareness of the socio-cultural, political, linguistic and historical context in which the interview takes place, as well as those that relate to the research question and individually to each participant's unique narrative. As a constructivist, I remained sensitive to context by having a homogenous sample of Israeli mothers, and yet considering how the characteristics of our Hebrew interview should be retained in translation. Societal context contributed to my research question as I have pondered "why has the focus on DE in motherhood been placed on its impacts on children – what about the individual mother with a subjective experience of this?" In perusing the literature, I considered the importance of stigma on mental health difficulties in mothers; the extent to which mothers are seemingly to blame for not 'controlling' their own struggles. This context, alongside societal pressures on women's thinness, contributed to my focus on mothers' individual experience of DE.

Commitment and rigour can be reflected in efforts taken by the researcher to carefully and responsibly engage with data. This includes consistently approaching each interview with the same level of in-depth interpretation. By consistently following the IPA process outlined by Smith, I ensured that data collection and analysis resulted from intentionally rigorous and reliable work. This was facilitated by keeping a reflexive journal throughout, which also contributed to Yardley's third criterion of 'transparency'.

Furthermore, any deliberations regarding making changes in recruitment or data collection were discussed in research supervision, all-the-while considering evidence supporting these decisions as well as ethical repercussions of these. Therefore, I had other sources of input to assure my rigour and commitment and to demonstrate it transparently. By depicting my research process through images and outlining it in detail, I further demonstrate transparency and coherence. Relating my methodology and analysis to the literature review and the study's rationale further aims to create a coherent image of my work.

Lastly, I focused on the impacts and importance of exploring the mother's experience of DE in terms of CoP and other therapeutic practices. By conducting Hebrew interviews, I contributed to the impact of the knowledge of mother's experiences so that future research and practices may be informed by diverse populations. By better understanding mothers' experiences of DE, we can better prevent their struggles and better support these individuals as well as those around them that may be affected (e.g., their children). I remained aligned with the importance and impact as described in others chapters of this thesis.

Summary

This chapter provided an account of the methodology I have chosen, IPA, and the processes taken in data collection, preparation and analysis. In doing so, I have reflected on epistemological and methodological clarity and the importance of reflexivity with these in mind.

Analysis

Chapter overview

This chapter will demonstrate my analysis of participants' accounts of their lived experience with the re-emergence of DE in motherhood. Participants' accounts, as portrayed through extracts and the lens of the interpretative analysis conducted, will be interwoven into the categorisation of themes. The findings are laid out through three super-ordinate themes that intend to capture the essence participants conveyed about the quality, texture, and perceived dynamics between motherhood and re-emerging DE. Each super-ordinate theme is divided into three to four sub-ordinate themes, further distinguishing the interpreted meanings. The themes aim to depict both the shared (i.e., cutting across participants' accounts) and the unique aspects of each participant's interpreted account.

The analysis included engaging in a hermeneutic circle between my own sense-making of participants' sense-making process of experience. Since sense-making is a subjective process in this context, it is important to highlight that the themes resulting from my analysis would likely differ from another researcher's interpretation of the same data. Additionally, the researcher forms part of the data collection and is thus unique to the interaction between researcher, participant, and manifold factors. Even a repeated interview with the same researcher and participant would likely differ. Due to the subjective nature of IPA, I follow Yardley's suggestions on transparency of the analysis process in order to validate rigour (Yardley, 2017).

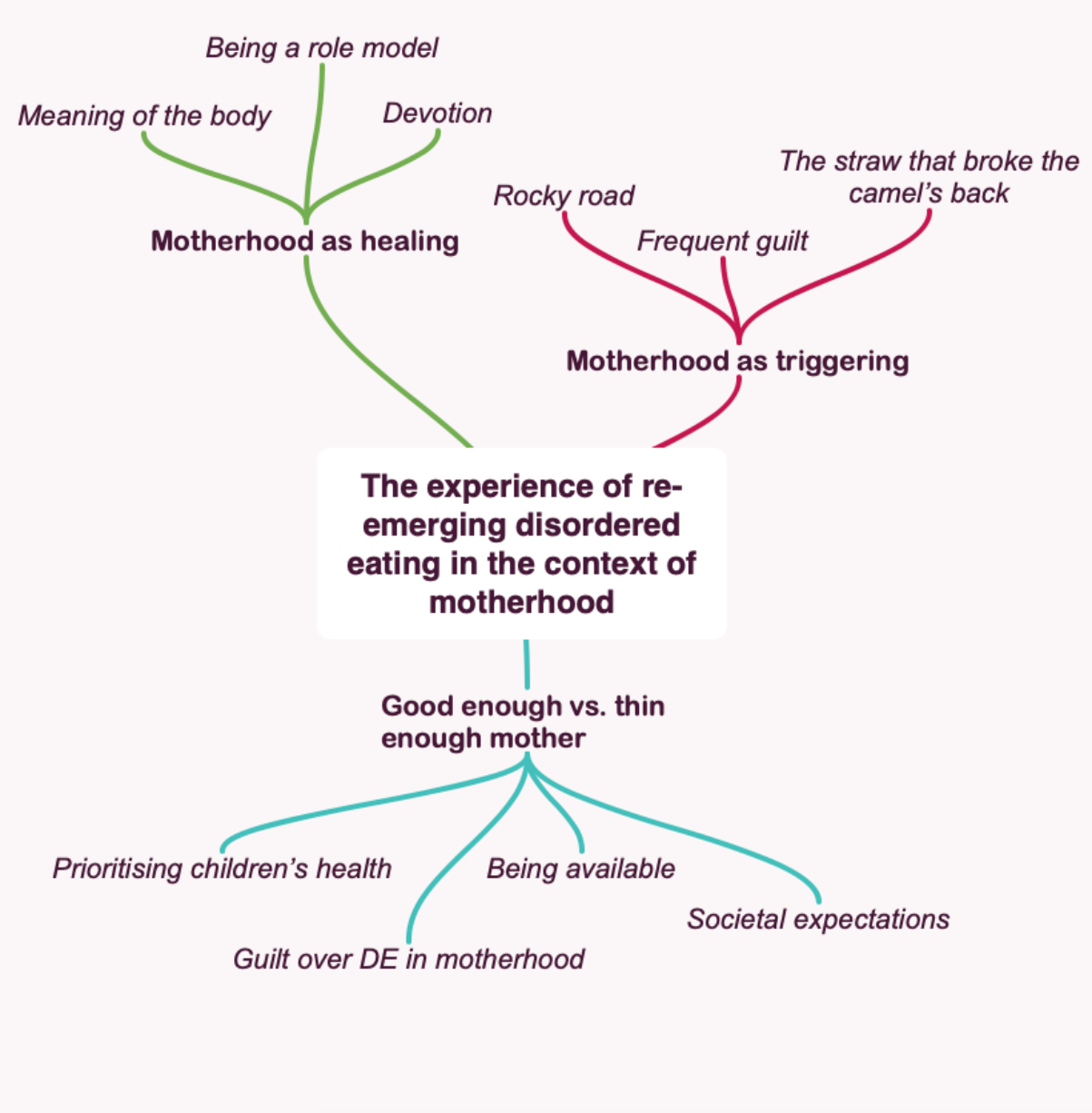
Importantly, extracts from the Hebrew-spoken accounts are instead illustrated through English translations. These do not accurately represent participants' voices (Van Nes et al., 2010), therefore, my translation needs to be considered as an interpretation (Willig, 2012). When specific language was deemed of particular importance to the re-counting of the experience, and thus potentially the experience of the phenomenon, I noted this and took this into my analysis process.

Super-ordinate themes are presented in a parallel fashion to my process of organising these, namely: (1) motherhood as relieving DE struggles, (2) motherhood as contributing to DE struggles, and (3) being a good enough versus a thin enough mother. While these generally follow the structure of the interview schedule, they do not necessarily reflect that of each participant's account. The three super-ordinate themes and corresponding sub-ordinate themes are presented in the figure below, Figure 1.

I describe each super-ordinate theme in terms of its meaning and multiple derivatives of their sub-themes, and provide participants' unique idiographic extracts that contextualise these themes (see Appendix J for Presentation Key for participants' quotes). Each extract is followed by an indication of the participant to which it belongs and where in the translated transcript (i.e., lines "x – y") it can be found.

Figure 1

A visual representation of the three super-ordinate themes and their corresponding sub-ordinate themes.



Super-ordinate theme one: "Motherhood as healing to DE"

When discussing the experience of re-emerging DE, most participants mentioned aspects of motherhood that seemingly 'fought off' distressing struggles with weight, diet, body shape and/or body size. In other words, despite the re-emergence of DE during motherhood, most mothers experienced periods where motherhood buffered against the severity of these struggles. On a case-by-case basis, motherhood as a temporary relief was understood differently. The individual meaning-making will be portrayed within each sub-ordinate theme: "meaning of the body", "being a role model", and "devotion". Each sub-ordinate theme represents a categorisation of different elements of motherhood relating to meaning associated with bodily changes, role changes, and the shift of focus towards having children. This super-ordinate theme was termed so in accordance with the way in which participants tended to praise motherhood, as reflected in the language used, when discussing its positive impacts on the self and when it alleviated struggles with DE.

Sub-ordinate theme one: "Meaning of the body"

This sub-ordinate theme depicts mothers' sense-making of fluctuations in severity of DE in terms of the meaning they attached to their bodies. In most accounts, it seemed that it was beneficial when mothers perceived their bodies as: a vessel to carrying the baby in pregnancy, a source of nutrition for the infant during breastfeeding, and resultant weight gain as reminders of this. In other words, it is when mothers perceived their bodies as important for the child's nutrition and care that they experienced less distressing DE, and sometimes found themselves loving and accepting their bodies.

> During the pregnancies I didn't have a problem with the weight gain. I felt pretty. In pregnancy, there was a wonderful excuse to feel wonderful, I'm not just saying the word 'excuse' for no reason, the word 'excuse' because it was... because... in my pregnancy I felt the prettiest, like, really like that. Every single pregnancy and I gained weight umm[ ]but during the pregnancy it was okay to be fat, it was okay. I really didn't have a problem with being fat. I walked around and I felt beautiful just like that. (Ivy, 9-15)

Ivy's understanding of a lack of distress with her increased weight can be understood as relating to pregnancy being an 'excuse' to accept the body unconditionally. In this way of

speaking about it, I interpret that Ivy is indicating that normally, in order to love her body and feel good in it, she must look a certain way, and that this spurs on a sense of urgency contributing to DE. In my process of making sense of Ivy's concept of 'excuse', I speculated that weight gain is unacceptable to Ivy when it is not justified as being for motherhood. In fact, weight gain can even be 'beautiful' when it is for pregnancy.

The idea that weight gain can be tolerated when its function is understood as giving rise to life of a new-born was mentioned throughout the interview with Juniper:

> To tell you that it didn't bother me, I would be lying to you. But it was a weight gain that was conscious... that is, I had life inside of me (Juniper 46-47). To say that it didn't bother me would be a lie. But you know I had to make that 'switch' mentally with myself, that it's temporary and that it's for the good of something that is magnificent, a spirit-a soul that I am raising inside of me (Juniper 49-51).

In Juniper's account, she seems to be indicating that attributing weight gain's purpose to raising a child is what distinguished Juniper's response to weight gain within pregnancy as opposed to without pregnancy. By giving the body the meaning of motherhood, it appears that Juniper was able to tolerate the distress that she felt when noticing weight gains. Juniper's mentioning of a 'mental switch' indicates that this process was a deliberate effort that she engaged in. In other words, it is not that there was an absence of pre-occupation or concerns about the body or food during pregnancy. Rather, it is that Juniper responded to these differently through an internal dialogue of re-attributing its meaning to motherhood, which she values and views positively.

Another participant described how the changes in her body shape and size in pregnancy, specifically in her belly, were understood as relating to pregnancy which 'excused' these changes.

> Listen, because when you are pregnant and you have a belly of pregnancy, like... you have an excuse of "okay, I'm pregnant". With the belly, with all the swelling, with all of that, with the oedema and that then you can like... live with it. The problem, the 'shock' that there was after the birth. Already in the hospital, even when I was still in pyjamas and I saw myself in the mirror when I went to bring the baby from

> breastfeeding. I looked at myself and... suddenly, you know, this big belly becomes just this big paunch in the waist that is not a pregnancy belly anymore (Poppy, 72-78).

In describing pregnancy as an 'excuse', Poppy may be alluding to the idea that a larger body size, and specifically around the belly area, is intolerable or unredeemable. One can get the sense that, as long as changes in the body can be externalised and where responsibility cannot be placed solely on the self, that you can 'live with it'. Poppy's description of the excuse as "okay, I'm pregnant", alongside an aloof tone of voice, suggested that she perceived bodily changes in pregnancy as out of her turf of control and responsibility. Similarly, 'live with it' indicated to me that when bodily changes could be explained by the force of pregnancy, this seemingly diminished the almost immediate sense of distress which were otherwise experienced before and after pregnancy. I interpreted from Poppy's account that the meaning associated with the bodily changes, rather than the observation of the changes themselves, elicited the most distress. This interpretation was based on Poppy's description of the 'problem' or the 'shock' occurring after birth, once the belly became a 'paunch' and lost its pregnancy-related meaning. In this case, making sense of bodily changes in pregnancy as emanating from nothing other than motherhood seemed to buffer against distressing pre-occupation that relate to Poppy's experience of DE.

Other participants also voiced similar meaning-making processes wherein bodily changes were experienced as tolerable in light of their relation to motherhood. Yasmin, for example, remarks on bodily changes following giving birth and while breastfeeding:

> It takes about a month and a half until I understand that, actually, that's it... Like... The baby is outside, the liquids are out, the bleeding is over, the... I don't know, the... Like... Everything that needed to come out has now come out, ehm... And now it's just me and the fats (chuckles). And then I think, I begin to process (literal translation: digest) it and understand it, and at the beginning I am still telling myself 'fine, it is still too early, I am also fully breastfeeding, I need it... It will come down', all kinds of things like that. More or less in this stage—when we are talking now—I understand already that it... That it is no longer related to the breastfeeding and it no longer is related to the... It's just that I ate too much in the pregnancy, and then the bummer arrives. (Yasmin, 78-85)

In Yasmin's account, she seems to describe the matter-of-factly aspects of bodily change (e.g., the weight of the foetus and liquids) in pregnancy and breastfeeding that she can remind herself of when she experiences distress regarding weight gain and changes in the body. Thus, Yasmin portrays to me an experience of distress once those aspects can no longer be relied upon, as the 'evidence' of that weight being attributable to the infant are no longer tangible. In other words, Yasmin's experience-as-told of bodily changes in early motherhood and how these serve as a temporary buffer against DE-related guilt is described more so in terms of the actual physiological explanations for weight gain rather than her body's role as a vessel. Yasmin's extract provides a glimpse at how, though most participants share a similar meaning-making of their bodily changes in early motherhood as a relief to DE, the individual experience and meaning-making is not identical. For some participants, the 'excuse' of weight gain in motherhood seems to relate to the body's role of providing nurturance for a dependable other, whereas for other participants (such as Yasmin), the focus is more on how bodily changes can be explained by motherhood therefore rendering these as tolerable.

Idiosyncratic accounts can also shed light into a different experience of meaning-making of the body in pregnancy and how this related to Sakura's experience of DE during pregnancy:

> Like, I really was in a struggle of like "no you can't gain a lot and you will gain a lot". And kind of like, my mum was standing in my head, and like because she gained in her pregnancies a lot so she was always telling me "but you have to think about it now so that you don't get disappointed later and you won't have to lose weight" and all kinds of stuff like that. So that accompanied the pregnancy itself. (Sakura, 13-16)

In this extract, Sakura's focus on weight gain during pregnancy seemed to be detached from the function of weight gain in pregnancy as related to motherhood. In her account, she describes a fear of weight gain seemingly informed by her mother's anecdotes of weight gain in pregnancy. In this discourse between Sakura and her mother, as well as what Sakura was communicating to me in the interview, I interpreted a lack of focus on the meaning of motherhood when Sakura thought about the meaning of her body in pregnancy. I have therefore included it here as a potential example of how the *lack* of an association of the meaning of the body to motherhood may render motherhood as being experienced as less healing to DE. This is especially of note when one considers the inevitable weight gain and

that other changes to do with the transition may be triggering – as is described in the next super-ordinate theme.

Sub-ordinate theme two: "Being a role model"

Most participants seemed to make sense of reduced DE-related distress as partly resulting from their new 'mother' title and its perceived 'role model' qualities. The knowledge that their children may look at them as an example for how to manage the relationship with their own bodies, food, or other emotional difficulties, seemed to spur most participants to lessen their reliance on DE.

> I decided that I want to be an example to my daughter. a) I want to be healthy in terms of health, b) I want to be an example for her that she grows up and understands that also 'mum eats healthy so it means that I obviously eat healthy' (Poppy, 178-180)

In Poppy's interview, she seemed to define being healthy as eating more regularly and being physically in good shape. The acknowledgement that her daughter might look to Poppy to know how to eat healthy, and therefore where Poppy served as a 'role model' and the one who set the example in front of her daughter, seemingly provided Poppy with ample motivation to 'be healthy'. In her narrative, it was implicit that 'DE' was conceived as the opposite of healthy eating, and that Poppy would potentially say that an unhealthy body would result from 'DE' and would prevent her daughter from developing a healthy eating style as well. I speculated that being a 'role model' in her daughter's eyes was a meaning that Poppy made of motherhood which was powerful enough to positively impact her eating behaviours.

Poppy's concept of setting an example in terms of her physical well-being was voiced in other narratives. For example, Hazel also talked about the importance of 'modelling' an example to her girls with regards to eating patterns in the home:

> I would like to change—in the house—the eating patterns... to give habits, uhh... to impart eating habits that are right. Uhh... so model an example to my girls. (Hazel, 234-237)

In Hazel's extract, she indicated that her will to change DE-related to 'right' eating habits relates to her desire to set an example so that her daughters develop healthy patterns of eating. It appeared through participants' narratives, that the presence of responsibility and

care for a child supersedes and pushes mothers to improve their DE more so than the acknowledgement that their own health and well-being is impacted.

The concept of 'role model' was also spoken about in terms of portraying to children a more accepting relationship towards the body.

> I would want them to see that even though I don't look like in the catalogues, I am satisfied with my body, so that they know that it is fine that way. [ ] Not only about themselves, also about others. In choosing romantic partners, in... Feeling of... Towards, their feeling with themselves... With who they are. (Yasmin, 173-176)

Yasmin's depiction of the example she wants to set conveys a hope that her own over-evaluation of weight, body shape and body size won't be experienced by her children towards their own and others' bodies. Yasmin indicated a desire to bestow a sense that aesthetics, as portrayed in popular culture, are not required for a loving attitude towards the self or others. These interpreted hopes and desires seem to relate to Yasmin's motivation to epitomise an example as their mother. In Yasmin's extract as well, the idea that she attempts to disregard DE that permeates her mind, is driven by that she is viewed by her children as a leader.

Sub-ordinate theme three: "Devotion"

As part of the experience mothers described of re-emerging DE, and part of the sense that they made of moments of relief, was their deep valuing of motherhood. The 'devotion' to nurturing the children appeared to manifest through: the energy and effort put in; how it preceded DE-related thoughts due to how highly it was valued; and how being devoted to motherhood reflected well onto their self-worth. These forms of 'devotion' seemed to 'offset' the energy and effort otherwise invested in maintaining self-worth contingent on engaging with DE behaviours that are deemed positively (e.g., restrictive dieting and weight loss) and avoiding the negative ones (e.g., binge eating and weight gain).

In Sage's interview, she described her recovery from a gastric bypass surgery which she had undergone as a result of feeling distressed by having rapidly gained weight in the post-partum period. Sage mentioned that, despite her fears of going 'under the knife', she had the surgery in order to improve her health and therefore be more available as a mother, which will be discussed further in another sub-ordinate theme. In the following extract, Sage illustrated how the devotion to taking care of her children extended beyond the DE struggles and encouraged her to fight the DE.

> Motherhood - I think it's the thing that's the most... It's my life, it's my happiness it's the... Really, like... I - everything is for them [ ] also the surgery as hard as it was for me and all that, they brought me back to life - to myself. That they come and they're like "mum, give me" and "mum, do this to me" so you get up even though you're hurting and even though it's... It's... Motherhood is... The best thing that happened to me in life, that's for sure. (Sage, 212-215)

Sage's way of describing motherhood as her 'life' and her 'happiness', as well as saying 'everything is for them', suggests that her attempts at overcoming DE and its negative impacts on her own well-being were spurred on by wanting her children to be happy. This alluded to a sense of being hard at work at the ultimate goal and ongoing process of nurturing the children, regardless of pain and discomfort. Powerfully, Sage's way of saying 'they brought me back to life - to myself' suggested that, despite this 'devotion' of nurturance to children seemingly coming as a self-sacrifice at times of pain, it paradoxically was healing to her as well. The intensity with which motherhood was valued seemed to underline this sense of devotion as seen by Sage saying 'motherhood is the best thing that happened to me in life, that's for sure'.

Similarly, it seemed that Sakura's valuing her motherhood was related to some relief in DE. Specifically, Sakura expressed that being focused on motherhood 'replaced' the energy and effort that she would otherwise place into pre-occupation with DE.

> There is something in it that it added a bit more value that I could put it a bit in proportion. So, like I don't know if like... I think that it gave me something to focus on and it gave me something that helped me feel like I was valuable so it also put things in perspective to focus on other people, so a bit more perspective in life. (Sakura, 135-138)

By indicating that motherhood 'put it a bit in proportion', Sakura suggested that motherhood is superior (as compared to DE) when considering where attention is more worthy of being allotted. Sakura's way of saying that motherhood was 'something that helped me feel like I was valuable' alluded to pride in her motherhood and a source of self-worth that, in turn, diminished the 'need' to try to derive this self-worth from DE. In this sense, the focusing on motherhood and how it reflected positively on the self, seemed to be Sakura's benefit from

devotion in her motherhood. Sakura further described her understanding of moments of relief in DE during motherhood:

> a) it (motherhood) gives me more value to the person that I am, like I feel that it widens a bit like who I am and gives me more meaning to life in that way and... And then in some way like other things like get their place, it like maybe takes a bit less space and also suddenly I care about other people, like you really care about them, and in some place it fills my thoughts, my worries, and then in some way, there is in that space less space to be worried about (DE-related concerns) [ ]. It also like can contribute to sometimes it will be a bit less difficult and then I will less get to places that are less good for me because something that will be a bit better for me in my life. (Sakura, 264-271)

Sakura seemed to convey that motherhood took up more of her thoughts and concerns and that these seemingly 'took place' of those otherwise relating to her DE. In this extract, Sakura emphasised the meaning she made of her motherhood as giving her value as a person. In light of the context of this interview as relating to DE, I interpreted from this that Sakura may have normally limited her value as a person as based on her body's weight, shape, size, and the appropriateness of her diet. In this sense, her devotion to her children seemed to distract away from DE-related thoughts and perhaps reduce the need for these, as her self-worth was no longer dependent on DE, but rather on perceiving herself as a 'mother'. Additionally, Sakura seemed to reflect that motherhood was 'better' for her, such that it potentially buffers against the struggles she might experience that normally give rise to DE. In this sense, it could be that Sakura's devotion to motherhood somehow 'fights off' the negativity of DE-related thoughts and struggles.

The description of devotion to motherhood as all-consuming so much so that it engulfs other aspects of her experience, including DE-related struggles, was also alluded to by Juniper:

> Do you know that feeling when you fall in love and you have butterflies in your stomach? It's that feeling but it's something else suddenly, you have that in the whole body, it's something that's from you, it's-it's a miracle! It's yours, somebody - it's yours, actually yours. It's your blood... It's exactly like that, and she is mine now. I am

> a mother; I have all of this. I am a mother. It's to sniff her, not just to smell her. It's touches of God in these small moments, there I felt the motherhood as something that is mine, actually (literal translation: net) mine from me. (Juniper, 130-135) I think it hatches and it comes from love. It's purely, it's… purely love that I waited for. I waited for it and I waited to experience it also. (Juniper, 179-180)

The notion that pregnancy resulted in the miracle of life, and that the baby was created from her own body, was seemingly entrancing Juniper so much so that she compares this experience to 'falling in love'. By saying 'you have that in the whole body', Juniper may be indicating that this kind of all-encompassing experience does not leave space for DE-related thoughts or experiences to penetrate. Juniper's way of making sense of her relief in DE related to an experience of motherhood 'hatching and coming from love' and emphasised by her valuing motherhood from a very young age ('purely love that I waited for'). In other words, Juniper could be alluding to the idea that when values related to her motherhood supersede those related to DE, motherhood dominates her day-to-day experience and eclipses the struggles related to DE. Juniper's devotion, as understood in terms of her being engulfed by motherhood and having waited eagerly for it, can be seen as her moments of 'escape' from otherwise distressing struggles with DE.

Super-ordinate theme two: "Motherhood as triggering to DE"

Participants tried to understand why it was that DE 'plagued' them in motherhood, and in this process, it appeared that participants were trying to pinpoint aspects of motherhood that may have contributed to the re-emergence of, or the worsening of, struggles with DE. In most participants' understanding of this phenomenon in the context of motherhood, it appeared that the transition into motherhood and the accompanying changes served as triggers for pre-occupation with body shape, body size, weight and diet. In this super-ordinate theme, I separate the 'triggers' of motherhood to DE in terms of (1) natural elements of the transition to motherhood, (2) a reduced threshold for guilt in motherhood as a precipitating factor to DE-related guilt, and (3) motherhood as a non-specific stressor contributing to accumulated overwhelming stressors. This super-ordinate theme is accordingly divided into three sub-ordinate themes: 'rocky road', 'frequent guilt', and 'the straw that broke the camel's back'.

Sub-ordinate theme one: "Rocky road"

This sub-ordinate theme contains the specific stressors in the transition to motherhood that participants seemed to describe as triggers to an enhanced pre-occupation with their body shape/size, weight and/or diet. It is termed 'rocky road' to capture the essence of my interpretation of the bumpy nature of the journey into motherhood in terms of the range of changes that, while adjusting to these, were described as triggering to DE. These changes are part-and-parcel with transitions to motherhood, for example: weight gain during pregnancy which is confronted after giving birth, less time available to exercise due to early motherhood responsibilities (e.g., breastfeeding) and reduced sleep due to being attuned to baby's crying.

Hazel described the 'leftovers' of birth and how this impacted her body shape and size, as well as how her diet and exercise were impacted due to motherhood-related lifestyle changes:

> There's lots of leftovers from the births, the body changes, it is harder to lose weight, it is not as easy as it used to be. [ ] Like you are busy with so many things: raising children and stuff, so less time uhh to cope with uh what kind of meal I'm eating now or to make myself a proper meal and to sit to eat [ ]… so that is one thing you cope with, the second thing is I am trying to exercise and also there are constant struggles between me and myself [ ]. To get up, to walk out of the house, to do exercise, it's not simple, again - when you have children. (Hazel, 16-23)

Hazel's word choice 'leftovers' potentially captured a difficulty wherein the body still had the 'extra' weight from pregnancy, yet, it is no longer serving this purpose and therefore something she wanted to be rid of. Hazel indicated that weight loss attempts were more difficult after the bodily changes in pregnancy. I interpreted (from Hazel's tone of voice and word choice 'it's not as easy as it used to be') a sense of frustration at the seemingly reduced malleability or responsiveness of the body to weight loss after birth. Additionally, Hazel seemed to attribute some of the DE that occurs on the behavioural level (i.e., eating) to lifestyle changes such as having less time. It also appeared that Hazel's DE-related pre-occupation of reliance on exercise as a compensatory behaviour to effect weight loss was harder to accomplish due to time restraints. In this sense, motherhood responsibilities were described as a barrier between Hazel and her responding to the pre-occupation with DE-

related concerns. Therefore, regular eating was seemingly disturbed simultaneously as distressing evaluations of the body were not able to be reduced through compensatory behaviours.

In participants' accounts, lifestyle and bodily changes seemingly 'got in the way' of attempts at weight loss that were valued and intrinsically tied into the demands imposed by DE-related pre-occupation with weight, body shape/size and diet. Additionally, some participants also described a perhaps hormonal change affecting their relationship with food.

> There are those that breastfeed that say that they get thin [ ] I breastfed I was starving… (laughs) I was hungry, all the time. I was really hungry. [ ] I'm breastfeeding and I'm hungry and that caused me to gain weight. (Ivy, 246-248)

In Ivy's quote, she indicated that breastfeeding enhanced her baseline levels of hunger. I interpreted a sense of a lack of control over the body's request for food, and therefore a sense of a lack of control over the resultant weight gain. In this quote, Ivy reflected on conversations amongst other mothers and perhaps a disappointment in the lack of the experience of 'getting thin' during breastfeeding by comparison. Ivy's experience of weight gain after birth, whereas she seemingly was hoping for a weight loss, illustrated another aspect of the 'rocky road' of the transition to motherhood. Namely, physiological or hormonal changes in appetite that can be experienced as overwhelming and as out of control, and contributing to DE-related concerns.

The contrast in bodily shape and size, as well as a sense of a lack of control over weight and appetite changes in the 'rocky road' to motherhood, was also described by Poppy:

> It's not my body, that it doesn't resemble what I had, I don't have a flat belly... Uh... I had in the area of the hip - my belly was wide like in the area of the hips. All of me wasn't me [ ]It's frustrating, I was really frustrated, I was disappointed. I couldn't look at myself, or even groom myself or even dress nicely. [ ] When I stepped on the scale, I understood what situation I am in... This I am talking to you about I dared to weigh myself two months after. In this whole period, I was really... I tried to fight the weight since the birth. [ ] I was like in diets from the first week but probably my body doesn't respond right after birth, and that's even more frustrating. (Poppy, 81-88)

In Poppy's extract, she began by describing what seems to be a lack of identification with her body after the termination of the pregnancy ('all of me wasn't me'). In that sense, it could be understood that Poppy sought an identity-related stability by looking at the shape and size of her body which have altered. In essence, Poppy's frustration with the changes in body shape and size were inextricably bound to meaning associated with her body as an important part of her sense of self. Poppy's experience of DE is described as emerging from this frustration, and resulting in avoiding experiences (e.g., grooming herself or dressing nicely) for fear that these may trigger more frustration with body shape and size. Poppy seemed to detail a struggle with DE as her fears were confirmed when she 'dared' to face the reality of her weight, followed by constant weight loss attempts to 'fix' the distress with her body shape, size and weight. Similarly to Ivy and Hazel, Poppy also referred to the body responding differently to weight loss attempts after pregnancy, seemingly exacerbating her frustration with DE struggles.

Sage also seemed to describe an overwhelming hunger that potentially was contrasted with her experience of hunger in the pre-partum period, and potentially before pregnancy.

> You're hungry all day, and if you're not hungry - if you're not eating, you are frustrated, and... And you're just a mum and you don't sleep at night and... It's like it's kind of uh... There's some comfort in food that you just, you also do it without paying attention. You're here eating just because you're at home all day and have nothing to do and you're with the baby and he's crying and... So, you are busy with him all day... And being at home so you're eating all the time and... I am also telling you - every time I breastfed him, I also felt this strong hunger and I would also eat quantities of food. (Sage, 31-36)

Specific to Sage's experience of pregnancy, she described nausea that was so severe that she was averse to some sensory experiences (e.g., specific sounds). Therefore, her post-partum experience of hunger was described in her interview as contrasted with nausea in pregnancy. As such, it is important to consider that the experience of a lack of control over appetite and weight gain after birth could also relate to an overwhelming contrast between the experience of appetite during and after pregnancy. Sage ties in DE during motherhood to a sense of boredom as well as a frustration with a lack of control over her infant's moods that are coped with using food. This can be interpreted through Sage's mentioning of food as

comfort. In her extract, Sage seemed to be describing an intensity of experiences in motherhood that were potentially previously unfamiliar, such as being at home all day, not sleeping at night, hunger during breastfeeding, and being dependent on the infant's crying to structure daily activities.

This repeating narrative of DE as related to lifestyle changes according to motherhood responsibilities and the availability of time was also voiced by Sakura:

> To invest in healthy eating like all those things that you have to do in order to be skinnier, so I am less able to do because I don't have much time, I don't have much time to invest in healthy food, or to go out to do sports, like all requires things. Like if you are able to go out for an hour it's like wow. Likely it will be difficult to do that once a day, and also you are... I am often exhausted so I have no energy. (Sakura, 185-188)

Sakura seemingly alluded to DE in motherhood as relating to a lack of time to regularly eat and exercise 'healthily' in order to lose weight and be 'skinnier'. As mentioned previously, the value of thinness or the fear of weight gain tend to be tied to the experience of DE. Sakura also mentioned an exhaustion potentially in the sum total of the intensity of the rocky road into motherhood, which she experienced as preventing her from having a regularly clear mind to respond to and prevent DE in motherhood.

Sub-ordinate theme two: "Frequent guilt"

Many participants indicated that they frequently felt guilty as mothers for not being 'good enough mothers', which seemed to be understood in terms of feeling mad at their children in contrast to their expectations of themselves to be perfectly containing and serene mothers. It seemed that participants found resultant guilt emotions as creating a baseline of feeling guilty regularly in their motherhood, which in turn made them more sensitive to DE-related guilt about appearance, and/or, was coped with through DE. That is, the frequent experience of guilt in motherhood seemed to precipitate DE to cope with that.

> Like on a day I am mad at them or something then I like I have lots of guilt feelings... I really eat myself, that - yes. (Sage, 239-240)

In Hebrew, it is common to say 'I ate myself' as a way to describe an experience of internal self-berating. It is interesting that this phrase was used by many participants, describing the

experience of guilt in motherhood, as well as encapsulating perhaps the more literal sense of 'eating' as a response to that guilt. In Sage's interview, she connected her experience of guilt in motherhood to emotional eating. It appeared that her understanding was such that she experienced guilt for expressing anger at her children, and then criticised herself harshly. I interpreted this as though anger was unacceptable to her ideal version of a mother and, as described in another quote in Sage's interview ("you always feed yourself and you're down" – 192), that these guilt feelings and self-criticism precipitate emotional eating. Though Sage's understanding of the link between eating when she feels down or 'guilty' can only be speculated, it appears that part of her experience of DE related to emotional eating in response to guilt that arose in the context of motherhood.

In Sakura's narrative, I noticed a similar thread of a sensitivity to feeling guilty about expressing anger at her children, and berating herself for this. Eating perhaps was an attempt to assuage the intensity of that guilt, which may feel intolerable when one deeply values motherhood and associates it with unyielding containment.

> It can be a moment of whatever – I got mad and later I will 'eat myself' and then I will… Whatever, will be critical with myself and then either it will lead me to eat in a certain way or it will, for whatever, feel bad and it will somehow connect to all that I feel towards myself and it all connects together… (Sakura, 150-152)

Sakura described a reduced sense of self-worth due to not being the 'good enough mother' by either experiencing and/or expressing anger towards her children. She seemed to tie in this sense of inferiority in motherhood to generally feeling bad or unworthy in herself. If her sense of self-worth is linked to her body and eating, such 'wildfire' experience of guilt seemingly then spreads to DE-related topics. In other words, the experience of guilt in Sakura's motherhood seemed to serve as a sensitive threshold to feeling 'bad' about the self which includes the body, and then coping with those negative emotions with DE-related behaviours or pre-occupations.

> Even though by and large in my eyes it is legitimate to get mad sometimes, it seems fine to me, but when it happens then sometimes I feel it's like... [ ] I had no patience in that moment and then I eat myself 'why don't you have patience' 'why not this' 'why are you not available 100%?' why not blah blah blah, like.. Like that. [ ] Lots of

scolding myself, which a lot of the time leads to some kind of emotional eating. (Sakura, 170-175)

In the above quote, Sakura indicated that while she rationally understood her anger at her children, she nonetheless tended to be self-critical. Her narrative implied that a 'good enough mother' is '100%' available and patient, and is able to contain anger. It is possible that such guilt (relating to her deep valuing of motherhood and the associations with it), is difficult to tolerate and is attempted to be reduced via eating, a coping mechanism seemingly familiar to Sakura's experience of DE.

Similarly to Sakura's account, Yasmin also voiced the role that guilt and self-criticism play in both motherhood and DE:

> Well, motherhood is saturated with guilt (Yasmin, 128) [ ] Sometimes I just, you know, sometimes I feel that in the guilt there is something in it... She (the guilt) creates ingredients of self-destruction. Eh and then... The eating is... It is undoubtedly the best friend of the... The mechanism of self-destruction. (Yasmin, 134-136)

Yasmin seemingly normalised motherhood as 'saturated with guilt', as though it is to be expected for mothers to regularly feel guilty. Yasmin seemed to vilify the experience of guilt as it provides the ingredients for self-destruction, which for Yasmin was experienced as emotional eating. In the context of my interview with Yasmin, she likely described this self-destruction in terms of her perceived vicious cycle between eating, self-criticism, and guilt as exacerbating one another to produce DE in motherhood. Yasmin's experience of the vicious cycle of DE was seemingly understood as relating to her DE-related guilt resulting from any eating that was not 'restrictive', especially if it was emotional eating. In this way, Yasmin seemed to make sense of her DE in motherhood as related to it serving as an emotional eating; a response to an expected frequency of guilt in motherhood. Taken together, Yasmin's account indicates that she frequently feels guilty in motherhood, which is responded to with emotional eating, thereby contributing to further feelings of guilt and resulting in a vicious cycle of guilt in the interaction between motherhood and DE.

Sub-ordinate theme three: "The straw that broke the camel's back"

Participants seemed to indicate that it is not necessarily just the specific aspects of motherhood which may be triggering (e.g., bodily and lifestyle changes and the frequency of guilt). Rather, motherhood was sometimes experienced as generally stressful, and when this

combined with other life stressors (e.g., at the workplace) it was difficult to cope with. The accumulated stress thus seemingly exacerbated a reliance on DE which, in the long term, did not resolve the motherhood-related stressors. Therefore, this sub-ordinate theme is termed 'the straw that broke the camel's back' to try to capture the un-specific nature of motherhood stressors, like many other stressors, which predispose one to emotional and psychological difficulties such as DE.

> Let's admit that really in our lives, by and large, are a series of overload or stresses, ups and downs, engaging in 'all over the place', life is loaded, life isn't simple [ ] But I think that, by and large, I think that when I am more in stress, maybe if I think about compensation, maybe then the food that that really is compensation. I didn't say what the compensation is for - right that you asked me? Maybe in stress there is when I am… feel what I would call being 'all over the place', it's too much, it's more than I can or want to. Or I feel that it is coming well to me. Okay? Now, maybe in that place really you can bring in also motherhood because here also you go through stuff [ ] that are not simple. (Ivy, 272-279)

Ivy indicated that difficult patches in life may elicit stress, and that these affected her experience of emotions as less focused. In turn, this 'less focused' state of emotions seemed to lead to an attempt to recover better mood in an immediate way, often in the form of emotional eating. Ivy seemed to describe an experience of uncontained emotion ('all over the place'), and that this feels overwhelmingly distressing, perhaps leaving Ivy to search for food as a way to compensate for low mood. In Ivy's way of understanding motherhood as relating to an experience of DE, she explained that difficulties and stressors occur in that domain as well as other life domains, and that a scattered and uncontained state are responded to with DE.

Yasmin also alluded to a sense that motherhood may serve as a stressor, and that there is a certain threshold for managing stressors in a way that is not through DE:

> And yes, my husband was doing his specialisation, it was... It was less of a good period and then I was screwed (literal translation: I ate it) and I felt those feelings more. The more complicated feelings. [ ]And that's why I say that it is a vicious cycle

> because it, each in its turn exacerbates the other, exacerbates the first, exacerbates the other... It's like... A mess. (Yasmin, 148-151)

In Yasmin's narrative, the aforementioned threshold was met when taking care of two young children simultaneously while experiencing a lack of support in managing motherhood responsibilities due to her husband's career-related responsibilities. Yasmin seemed to indicate that it is not just the specific aspects of motherhood which are distressing, but the lack of support in other areas of life that would otherwise serve as buffers against meeting the threshold of despair, and thus exacerbate the stressors in a cyclical manner. This repeated exacerbation of stressors or lack of support, in Yasmin's way of making sense of DE in motherhood, potentially is also part of how DE re-emerged in motherhood. That is, if she experienced stress in her life in general, motherhood stressors could've been felt more intensely thus contributing to more struggles with DE.

Poppy also indicated that there was an element of dependency between stability in the multiple domains of life and an overlap in terms of her sense of self-worth:

> All the factors relate to one another. If I feel good at work then I feel good with myself and then I feel good in the circle of parenting or good in the circle of how I look and so on. It's circles that relate to one another. So, if one falls apart maybe that also impacts all the rest. (Poppy, 211-214)

Poppy suggested that a positive sense of self-worth or stability, in any domain in life predisposes that same experience in other domains. As such, it could be inferred that if her experience of herself in the workplace or as a parent was negative (indicating the un-specific nature of self-worth in motherhood as a general sense of self-worth), that this in turn exacerbated a negative sense of self-worth when she attributed it to her body as well. That is, Poppy explained that DE in motherhood related to a sense of inferiority or struggle in her life that predisposed her to feeling negatively towards herself, thus coping less stably with DE.

Super-ordinate theme three: "Good enough vs. thin enough mother"

Voiced in all participants' accounts of the experience of DE in motherhood were reflections on having experienced it at all in motherhood. There was a sense of conflict between DE and motherhood, as though the two should be kept separate, and/or a sense of guilt over having experienced DE in motherhood. Many participants described a difficulty in bridging between

the demands of their sense of self-worth as contingent on thinness and their sense of self-worth as contingent on being an all-containing mother. As part of the conflict between DE and motherhood, it seemed that participants' way of making sense of these often related to trying to sacrifice their needs in terms of engaging with DE to prevent the development of DE in their children. This super-ordinate theme attempts to depict the dichotomy that most participants seemed to describe between DE and motherhood, or more specifically between being a 'thin enough' as opposed to a 'good enough' mother. The name of this super-ordinate theme was inspired by Yasmin's quote which is described under the sub-ordinate theme of 'societal expectations'. The conflicts between the dichotomy of these two sources of identity (i.e., motherhood, and thinness related to participants' experience of DE) are described through four sub-ordinate themes: (1) prioritising children's health (i.e., the sense of 'sacrificing' DE related self-worth for the sake of promoting physical and psychological well-being in their children), (2) guilt over DE in motherhood (i.e., the regrets and self-criticism mothers voiced as thinking of themselves as 'bad' mothers for having their DE enter motherhood), (3) being available (i.e., that DE took away from participants' availability to engage whole-heartedly with motherhood), and (4) societal expectations (i.e., the input of the societal valuation of thinness ideal when it is otherwise contradictory to their availability and engagement with motherhood).

Sub-ordinate theme one: "Prioritising children's health"

Most participants indicated that they tried to 'model' a healthy relationship with food and the body which they hoped refrains from instilling concepts that would later on give rise to DE in their children. Particularly in this sub-ordinate theme, extracts are used to indicate the push-and-pull and sometimes confusing considerations to make when attempting to focus on children's well-being while trying to manage DE.

Hazel described how her eating was often exacerbated by the kinds of foods she would want the children to have available in order to potentially prevent the emergence of DE for them.

> If I have in my house snacks and if I have cookies in the house, I eat and then I am mad at myself that I eat. I don't want there to be snacks in the house. Me with myself, I would prefer there wouldn't be anything in the house so that there wouldn't be the option to deviate uh but uh what's right for my girls? (Hazel, 128-131)

In this quote, Hazel voiced the conflict between managing her DE and promoting well-being in her children. On the one hand, she mentioned that a lack of particular foods would likely prevent feeling guilty about eating certain foods, and therefore reduce her struggles with DE. On the other hand, this is seemingly in contrast with what she deems as best for her daughters to develop a relationship with their bodies and foods that is free of DE. Hazel often enabled the presence of these snacks in the house despite its exacerbating effect on her DE, potentially because she prioritised preventing DE emergence in her children over preventing her own struggles with DE. I wondered whether, in this sense, motherhood served as a constant push-and-pull with DE as her considerations of foods involved an attempt to prevent the seemingly fragile possibility of the eruption of DE in her daughters, even at the cost of her own increased struggle with DE.

Juniper also voiced a conflict between wanting to 'respond' to her DE by cooperating with its demands and doing what is best for her daughter's well-being (ultimately being resolved in terms of the latter):

> Let's call it more of a consideration "I am eating now just salads so that I lose weight" but salad doesn't help me because it doesn't have the fibres and all the things that are required to make milk... So… it's a consideration that I need to make and to take it at that very moment. (Juniper, 323-325)

Juniper's example is that of choosing between a food that would promote weight loss (and therefore respond to her DE identity and source of self-worth) as being in opposition to what is most nutritious for the breastfeeding of her daughter (and therefore strengthen the source of self-worth from the mother identity). In describing this dichotomy, it could be speculated that whichever decision she made, Juniper could 'berate' herself from whichever identity or source of self-worth that was not fulfilled. This illustrated a seemingly double-edged sword situation that Juniper experienced when she dichotomised being thin enough as opposed to a good enough mother. The consideration here relating to being a 'good enough mother' is that of promoting the child's health in terms of supportive nutrition.

Yasmin also discussed how her identity and sources of self-worth were simultaneously contingent on motherhood and thinness. In her quote, she depicted how it is often difficult to assert whether her eating and relationship to her body is modelling a healthy relationship for her children to be free of DE, or whether it is as part of her own DE, which therefore would conceivably be passed on to her children.

> I am a woman, I am a person, I am a mother. I think that that I am a mother is the first thing I would say about myself so all that there is in my life affects that and is affected by that. And also the topic of how I look because I can tell myself one day 'it is important that I look thin and I do exercise and I look healthy for the children so that they have those habits and that trait' and it really easily can go for me to the edge of nonstop pre-occupation with it.. And... And then I tell myself 'hold up, that also hurts the children' so almost everything at the end of the day - almost everything is related to it. (Yasmin, 226-232)

Yasmin's extract begins with aligning herself with which aspect of the three identities 'woman', 'person', and 'mother' fuel the considerations between her values of motherhood and those relating to DE. She indicated that her mothering identity bridges the decisions she makes, yet this leads her to encounter a fine line between being fuelled by a role model of a mother that prevents the development of DE in her children, versus one that encourages it and fuels her own DE as well. Yasmin seemingly recognised that an intention to model a healthy relationship with her body and food to her children could often get out of hand and become an obsessive pre-occupation that then seeks to respond to a more DE-related goal. In Yasmin's process of managing DE in motherhood, therefore, it seemed that she intends to align herself with the intentions of her behaviours as either prioritising her children's well-being or (less frequently) prioritising her DE, and that it is often confusing when some grey areas exist.

Sub-ordinate theme two: "Guilt over DE in motherhood"

The dichotomising of DE as opposed to motherhood, as though one is bad and another is good, naturally would result in an experience of guilt over the presence of DE in motherhood, as one attempts to keep 'bad' away from 'good'. The presence of DE in motherhood, and its impacts on the experience of it as well as on the imagined experience of the children, was therefore described by most participants as guilt-inducing and uncomfortable to reflect upon. As participants believed that their DE would negatively impact their children's well-being and relationship with their mothers (i.e., the participants), they felt guilty and as though they were 'bad' mothers if DE permeated the domain of motherhood in any way.

For example, Hazel's desire to show her daughters what 'correct eating' was, in order to prevent their experiencing DE, was seemingly followed by self-criticism and the emotion of guilt when she believed she did not accomplish this on a regular basis.

> The best education is personal example and if I want to impart in the house correct eating uhh change in eating habits so uhh that needs to start from me and it doesn't work that way uhh… I am scared that the girls uhh will develop eating habits that are not right and god forbid eating disorders, but no, it doesn't happen in me any change which is not—which is not right… It is not right to conduct yourself like this… wrong conduct. (Hazel, 228-232)

Hazel seemingly perceived DE as getting in the way of modelling 'correct' eating, and therefore viewed her DE as putting her daughters at risk of developing EDs. The extent to which Hazel views EDs as a threat to her daughters' well-being can best be seen by her use of the term 'god forbid' which, in Hazel's case, is regardless of spiritual beliefs, but rather as a figure of speech to indicate how harmful these are. The view of EDs as a danger to her children, and her own DE as perhaps getting in the way of the prevention of these in her daughters, seemingly gave rise to Hazel's self-blame and self-criticism. Hazel's description of 'it is not right' implied a guilt over her DE in motherhood, as though it is something she is to blame for. In Hazel's extract, she lamented that the desire for her daughters to be well and not experience DE does not spur a positive change in her own DE. In other words, Hazel seemed to feel guilty for not being able to, so-to-speak, 'shake off' her DE in light of its potential damaging effect on her daughters.

Sage also voiced a guilt over the presence of DE in motherhood, but described it in terms of the impact it had on her mood and therefore the experience that her children had of their mother.

> The children, they had a pretty bitter and annoyed mother, if I am annoyed with myself then, naturally, they also experience those feelings. (Sage, 162-163)

Sage's apparent guilt over the presence of DE in motherhood seemed to relate to a sense of wanting her children to not experience negativity. Therefore, as she understood DE to impact her mood and interpersonal style to be 'annoyed' and 'bitter' towards herself and therefore others, it seemed that she felt guilty that her children were exposed to such negativity. I

interpreted Sage's communication here as indicating a valuing or expectation of motherhood as 'all good' as opposed to DE as 'all bad'.

> Lots of guilt feelings that you, like... You feel bad with yourself and sometimes it comes out on the husband and the kids... And then guilt feelings arrive—why did I act like that? and why was I mad? why was I angry at my boy? why is he to blame? and... You're always feeding yourself and you're down… (Sage, 190-192)

Sage expressed her understanding of feelings of guilt about DE in motherhood as emanating from her expression of anger towards her husband and children when, in retrospect, she believed these are simply 'side effects' of her struggles with herself and her DE rather than being 'called for'. Therefore, it seemed that Sage viewed her expression of anger towards the children as resulting from her DE and being improperly expressed onto her loved ones, and particularly her children, when it is not their fault. This seemingly left Sage looking for someone to blame instead ('why did I act like that?'). Sage seemingly blamed herself for her DE entering the motherhood arena and resulting in her expression of emotions which she potentially does not agree with in accordance with her positioning motherhood as all-containing and 'perfectly reasonable'. Sage added that this in turn exacerbates her DE as emotional eating is used to cope with that, leading to a vicious cycle.

Poppy's experience of guilt over DE in motherhood also seemed to stem from the deep valuing of motherhood and the expectation that one is whole with their motherhood.

> I terribly wanted to be a mother, I look at her (my daughter) as treasure that... Like, I don't know, I take my whole life, and I was born again, on the other hand I am saying "okay maybe it's her fault that I am fat" maybe it's because of her I, like, today cannot live my life as a single woman even for a second to buy a bag of milk [ ] You are not really free or that you cannot move easily. Everything needs to be a project... But slowly slowly it passed, like, it took me a bit to digest it but all good. I felt like bad that like I shouldn't think like that... And on the contrary, I earned like something good in life and that is worth everything. It is worth the weight, it is worth the coping. (Poppy, 139-147)

Poppy seemed to reflect on a frustration with motherhood challenges (‘you are not really free'), and guilt over negatively experiencing something about motherhood. This can be seen by her saying ‘I felt like bad that like I shouldn’t think like that’. Poppy expressed a thought that it is her motherhood, or her daughter, who is to blame for her distressing struggles with DE in motherhood. Reflecting on this thought, Poppy seemed to scold herself and feel guilty for even ‘wrongly’ associating something negative to her motherhood or to her daughter. It seemed that she responded to these thoughts by reminding herself of the positivity of motherhood as ‘worth everything’.

Yasmin’s concern that her own DE could impact her children came up during the interview as she was caring for her 3-month old baby and seemingly jokingly said to her baby in a higher pitched voice “I hope you don’t understand what we are talking about, I hope (chuckles), I hope that you don’t suffer like this”. When I asked Yasmin to tell me more about this, she told me:

> Look, it is very worrisome... There is a lot... Eh, like because I am pre-occupied with it, then I am sure that they hear... My children know that there are certain foods at home that are diet foods of mum so because they are not healthy for them, then they don't eat them... They know that I am very busy in that area, also... [ ] So yes, I fear that it is so. I fear that, you know, just the fact that I am occupied with it, and they see my pre-occupation in it, that it affects them. Ehm, I am sure that it is there. [ ] It's also the feelings of guilt but also a lot of responsibility. Like, I think that parents have a responsibility in this topic. (Yasmin, 158-171)

In Yasmin’s descriptions of pre-occupation and concern over the presence of DE in the house such that it is noticeable by the children and therefore impactful, seemed to elicit feelings of guilt alongside a sense of responsibility. That Yasmin felt guilty about this alluded to the notion that this impacting the children is ‘negative’, such that her experiencing DE in motherhood and it being manifested in the household where children can be witness to it, is something for Yasmin to blame herself for and to feel guilty about. In her interview, she expanded further on her guilt on DE in motherhood, indicating that she might be feeling guilty for expressing self-criticism in the household, which she viewed as something that can be passed on, as it is being ‘suckled on’ and ‘shared’ by her children.

> It is obvious that I am a self-critical person not just in the topic of weight, it's just that in the topic of weight it is a daily thing around the clock. But I am critical towards myself not just in that. I think that also from that - also that, they are suckling and sharing. (Yasmin, 178-181)

As such, it appeared that Yasmin's guilt over DE in motherhood is a guilt about her children potentially learning to be self-critical with themselves beyond the scope of weight, body and dietary realms.

Sub-ordinate theme three: "Being available"

Most participants also described DE as intruding upon their experience of motherhood, particularly in that they felt they were less available in their emotional and mental states to nurture their children in accordance with their expectations.

Juniper described, in retrospect, the decisions she seemingly made when she noticed pre-occupation with her weight, body and diet, in terms of whether to 'engage' with these whilst being at the risk of being less available as a mother.

> So I have two options and out loud I said it: either I can lie down and I won't give everything she needs and be a mother and it is sensed also… or I can say "it's okay, it's frustrating me to be in shit" in quotation marks "a few more months… we will take care of my body and that it will lose weight and and and" There is an option just to drown and you know… to sink, to be frustrated, to be depressed, or the second option is to be a mother in every way for this sweet thing… And to put the engagement with the weight and how I look a bit on the side, and there will come a time when I will take care of that. (Juniper, 335-341)

In Juniper's narrative, she indicated a contrast between DE and motherhood such that the engagement with one meant the lack of engagement with the other. She suggested that DE would affect her ability to be a mother 'in every way', in that she found herself drowning in it, and not giving her daughter everything she needed. Juniper's conveyance of a deep valuing of motherhood and wanting to identify as a 'good enough mother' seemed to be the backbone to this conflict between engaging with DE vs. being available to her daughter, where the latter was frequently chosen by Juniper. In this way of conceptualising the

dichotomy between motherhood and DE, Juniper alluded to the idea that DE took away from her cognitive and emotional availability to mothering as she was pre-occupied with DE thoughts and feelings instead.

In Sage's way of describing this availability, she similarly mentioned her emotions as being affected by the DE and therefore making her not a 'happy mother'. More so, Sage seemed to experience the physiological impact that DE had on her energy due to being overweight and fatigued.

> So that they have a happy mother. And so that I can run with them and play with them, something that I had a really hard time with before with my weight. I was very tired all the time, all the time wanted to sleep, now I am much more awake, much more with them. (Sage, 185-188)

Sage described her availability to physically engage with her children as impacted by her levels of fatigue from being over-weight resultant from her DE. She implied that, when her body is healthier and less 'affected' by the DE (as experienced by her in terms of a weight loss and reduction in emotional eating), she became more energised and in better physical shape and thus more available to her children. Sage not only expressed DE as reducing physical availability to mother, but also described an emotional unavailability:

> With how much that I am trying to be the best mum and... The most containing and to love them the most. It... When you're not whole with yourself, then everybody feels it. (Sage, 196-198)

By Sage's way of constructing this sentence, she implied that despite her attempts at being the 'best mum' which is containing and loving, the DE affected her availability to fully embody this as it negatively impacts her sense of self and, likely, her expressed mood. Sage seemingly described how DE penetrates her moments of containment with the children, and how this reduced her availability to entirely express that love and containment.

Sakura seemingly portrayed this notion of DE as relating to a reduced sense of self-love which impacted her mood and availability to emotionally contain and be the 'good enough mother' that she would strive to be:

> I suppose that if it (the DE) makes me love myself less and to be more impatient then it also affects everything. That is, it doesn't specifically relate to them (the children). But... [ ] it can affect my emotional stability on how I feel towards myself which in

> the end affects also how I treat them, that is in my opinion the relationship. The sensation that the more I do feel better with myself then in the end I will have more energy for them, and I will be more available and I will be with more patience... (Sakura, 224-228)

In the above extract, Sakura indicated that her impatience towards her children is irrespective of their behaviour, but that it stemmed from a general sense of impatience resulting from a crippling of self-love that accompanies DE. She described a resultant unstable mood alongside self-criticism as part of struggling with DE, and that this reduced her availability to be more patient, energised, and intentional about her behaviour around the children.

Sub-ordinate theme four: "Societal expectations"

Tied into many of the themes described in this chapter, and specifically in the ongoing push-and-pull conflict between DE and motherhood, was the underlying sense that societal expectations fuelled the importance of thinness and contributed to the ongoing conflict.

Sakura captured her conflict between engaging with DE during motherhood in terms of her agreement with the underlying thinness ideals or societal value judgments regarding particular ways of eating for females at her age.

> It's anger at myself and at reality, and also at reality that it even has to bother me right now. No, I want to focus on—I don't know, more important things—and not in... I don't know, in things that are in some ways less important. I don't know, there is also a side of me that also rebels against that. Like, it's not the most important thing in life, Like, I am not... Like, you don't have to go crazy. And like, it angers me that I even have that need and that, like, I need to scold myself and to say 'oh you're not a good girl because you're not working hard enough, you are not doing enough sport, you are not enough making I don't know salads and.. Taking control' so you're not a good girl, you are, like, not meeting the expectations of what is required of you as a woman of the age of 27 in our world right now, like it's together, it's anger at myself and the other hand, anger at the reality, like, why are you even putting me in that position?

> Like, I don't need to be there, I don’t really need to scold myself for it, like, I'm okay, I'm not really—I didn't really do something bad. (Sakura, 198-210)

Sakura seemed to indicate anger at herself and society (the ‘reality’) for placing the importance of a thinness ideal or a pre-occupation with diet in the first place. This pointed to a sense of disagreement with these values, yet an endorsement of these nonetheless, which were expressed as conflicting by Sakura. Sakura described her understanding of societal expectations as being a ‘good girl’ if she maintained the idealised weight, diet, and exercise regiment, that would mean she was ‘taking control’. Sakura’s ‘rebelling’ against these expectations manifests in her anger at herself for following these societal expectations despite disagreeing with these. Perhaps implied in this is an idea that if Sakura was at a different age or not a female, that perhaps these societal expectations would not impact her as much. I interpreted this as pertaining to her experience of motherhood as it is part of the context in which she experienced DE. In other words, I made sense of Sakura’s experience of DE in motherhood as related to her experience of societal pressures for particular ways of eating or appearing, therefore adding to the conflict she experienced within herself: to engage in DE or not to engage in it. This added another layer of complexity to this conflict. The first layer, as described in the previous sub-ordinate themes, related to the conflict between being a ‘good enough’ mother or being ‘thin enough’, whilst this layer pertained to the conflict between experiencing a freedom with these topics versus acquiescing to societal expectations.

> I think that many, let's say a high percentage of women, like, need to struggle with getting back to the pre-pregnancy weight that they put on in pregnancy and birth. There are those that have successful genes and they don't need anything that they come out a week after as if there was nothing. (Poppy, 350-352)

Poppy described her experience of DE in motherhood in the context of women ‘needing’ to struggle to return to a ‘pre-pregnancy weight’. In doing so, she seemed to allude to the idea that it is required for women to lose this weight, and it is possible that it is specifically understood as required by societal expectations. In describing that there are women who have ‘successful genes’ and do not need to ‘try’ to lose weight, it is potentially implied that a woman should expect to struggle to restore the weight that would be desirable by societal expectations. The use of the word ‘struggle’ indicates to me a reliance on DE, as this is described as something that is to be unnaturally forced, rather than something that would take place in its natural course of motherhood.

From Yasmin's extract, I interpreted that societal expectations of thinness in women and new mothers are viewed as contradictory to being entirely committed to the nurturance and containment in motherhood:

> To choose between to be angry and thin (chuckles), a mother that is angry and thin, or a mother that is nice and fat, really... It's… I know that it sounds dichotomous and harsh but, in my head, there is that dichotomy... (Yasmin, 116-117)

Yasmin dichotomises 'angry and thin' mother with 'nice and fat' as she described her engagement with DE in motherhood resulting in her expressing more anger due to being hungrier, as opposed to being attuned with her body and well-fed, therefore 'nice' but 'fat'. Yasmin's description of these two dichotomies echoes contradictory societal expectations: being a thin and 'presentable' mother and being an 'all-containing' and 'nice' mother. These societal expectations might be confusing and contradictory as they seem to require mothers to simultaneously be wholeheartedly devoted to nurturance and containment as mothers, whilst making continuous efforts to appear 'thin', which requires much attention. This attention is major in light of the quotes in this analysis indicating that weight loss attempts are more difficult to achieve during motherhood lifestyle and bodily changes. I interpreted that Yasmin's personal understanding of this dichotomy might originate or be influenced by societal demands associated with thinness in women, and nurturance in mothers. To sum, I interpret that the ongoing conflict between motherhood and DE is experienced as fuelled by societal contradictory expectations, which serve to promote an ongoing struggle between trying to meet the two all-the-while experiencing self-criticism from both edges of the sword.

As described by Ivy in the following:

> I think that the mother is most important to the mother, the mother is the most important to the child, and if the mother is not in the situation of—she won't be able to parent… 'a good enough parent' like it's hard, you really have to first care for the mother, the mother has to care for herself, the system needs to be really pro-mummies… (Ivy, 447-450)

Ivy alluded to the idea that the focus on being critical of mothers both in terms of looking at them under the microscope of being a 'good enough parent' as well as potentially being presentable in terms of being 'thin enough' does not enable the mother to truly be the best

mother she can be. Ivy indicated that these societal pressures result in the lack of care for the mother, and the lack of valuing of self-care in mothers. She indicated that in a paradoxical fashion, in order for mothers to thrive and be the best mothers they can be (in accordance with societal expectations), they must care for themselves and be supported by 'pro-mummies' society to care for their well-being.

Discussion

Chapter Overview

I summarise findings from my study including specific themes as well as any general conclusions. I discuss my findings in the context of my research question and aims, as well as previous literature. I critique my study by considering the methodology and its inherent limitations. I then offer implications for practice in CoP and provision of support to mothers. Similarly, I provide recommendations for future research in light of my findings. By the end of the chapter, I synthesise both limitations and implications as well as provide a summary of the thesis.

Summary of the Research

Analysis of the accounts by participants in my study highlighted that the experience of DE in motherhood can be a mixed bag. Cutting across themes and participants, a push-and-pull between motherhood and DE and the portrayal of these as contradictory seemed to be voiced in many ways. All of my participants talked about how being a mother gave rise to a new and contextualised experience of DE. For the most part, participants talked about motherhood as 'affecting' their DE in good and bad ways.

The superordinate theme of 'motherhood as healing to DE' captured the experience voiced regarding the 'good' impact motherhood had in such a way that DE-related struggles were either less present and/or more manageable.

The superordinate theme of 'motherhood as triggering to DE' encapsulated mothers' understanding of re-emergence of DE in the context of motherhood. Therefore, it could be perceived as indicating the ways in which stressors during motherhood 'negatively' intertwined with DE such that DE was more pronounced in those times. Taken together, the theme of 'motherhood as triggering to DE' could be perceived as contradictory to that of 'motherhood as healing to DE'. The experience of contradiction between motherhood and DE was focused on more in the final superordinate theme 'good enough vs thin enough mother'.

Discussion of findings in relation to existing literature

Superordinate theme one: Motherhood as healing to DE

Within this superordinate theme, the 'positive' effects that motherhood seemingly had on DE were divided into subordinate themes of: 'meaning of the body', 'being a role model' and 'devotion'. 'Meaning of the body' referred to participants' experience-as-told of

pregnancy and breastfeeding as giving rise to a new meaning of the body, thus painting experiences of changes in the body shape/size, weight and/or diet as promoting of wellness in the foetus or new-born baby. These findings echo those portrayed in the IPA study conducted by Tierney et al. (2011), wherein participants described an acceptance of the changes in their bodies becoming 'bigger' and 'fatter' due to their appraisal of the reason behind this change relating to pregnancy. The welcoming of the experience of expansion of the body in pregnancy, and even enjoying it (rather than simply 'tolerating' it), was described by some of my participants and was similarly mentioned in participants' accounts elsewhere (Madsen et al., 2009; Patel et al., 2005; Taborelli et al., 2016). In the meta-ethnographic literature review by Fogarty et al. (2018), the authors depicted the experience of bodily changes in pregnancy both in terms of it not being as distressing or 'repulsive' as expansion of the body outside of pregnancy, and/or in terms of enjoying weight gain in pregnancy as providing an 'excuse', rather than an uninvited change that would otherwise elicit DE-related guilt. These aspects were discussed similarly by participants in my study, with some idiosyncratic differences including enjoying the weight gain not only because of the enjoyment of food but also as the size and shape of the body were indicative of their motherhood, a value important to all of my participants. Fogarty et al. identified commonalities between studies in their literature review, including the notion that changes in the body were sometimes experienced as triggering to DE, in terms of mothers experiencing bodily changes in pregnancy as 'grotesque' as well as preparing to engage with compensatory behaviours in the post-partum period. Whilst the latter was mentioned by some participants in my study, the experience of finding the pregnant body as 'grotesque' was not voiced. As such, my study's sub-theme of 'meaning of the body' under the superordinate theme of 'motherhood as healing to DE' indicated that when changes in diet, weight, body shape and/or body size were rationalised as promoting life for children, mothers were not triggered to engage with DE-related behaviours, and sometimes even enjoyed these changes.

In my understanding of the present study's participants' accounts, motherhood's relieving effect on DE was also due to focusing one's energies on behaviours and attitudes that participants would want to be mirrored by their children, giving rise to my grouping this aspect under the subordinate theme of 'being a role model'. This somewhat resembles the experiences portrayed in other studies (Fogarty et al., 2018) wherein mothers' pregnancy-related remission involved mothers' consideration of their responsibility as a mother and how their engagement with DE would negatively impact their children. However, the experience voiced by my participants differed in that it encompassed an experience that extends beyond

pregnancy, as the responsibility as a mother that 'educates' her child continues throughout the child's life, especially as the child becomes more aware of surroundings. The focus on 'modelling' DE-related attitudes and behaviours was described by Tuval-Mashiach et al. (2013) and Stitt and Reupert (2014) as participating mothers expressed a fear of 'passing on' their struggles to their children. In Stitt and Reupert's study, this fear of modelling DE-related behaviours and attitudes seemed to give rise to mothers' making sure they practiced enough secrecy so as to not be noticed by their children. Tuval-Mashiach et al.'s theme of 'the child as a motivation to recover' had more to do with a fear of disappointing their children rather than a willingness to model a good relationship with food and/or their bodies. Yet, in the present study, participants discussed 'modelling' as an aspect of motherhood and its accompanying responsibility in a way that was healing to DE. In other words, not only was the fear of passing on DE discussed in other super-ordinate themes as a struggle between motherhood and DE, but it also served as a force to intentionally refrain from engaging with DE. This sub-ordinate theme sheds light into a potential window for intervention important when considering that remission during pregnancy can be followed by relapse during post-partum or later on in motherhood. Such experiences have only been suggested previously by Madsen et al. (2009) and Fogarty et al. (2018) as motivating to continued recovery for mothers.

Lastly, the attention participants gave to their motherhood seemed to serve a valuable distraction not only from DE but generally related to their valuing of motherhood, as depicted in the subordinate theme of 'devotion'. Vallido et al. (2010) discussed a similar theme of 'living to mother, mothering to live' considering the effects of mothers struggling from a range of physical and/or mental illnesses. More specifically to DE in motherhood, Tierney et al. (2011) outlined the shift in attitudes and behaviours in participants' experience of DE in pregnancy such that when their 'identity' was more absorbed by motherhood than DE, motherhood replaced DE in participants' lives. Literature exploring this aspect of the interplay between motherhood and DE *after* pregnancy is limited. The sub-ordinate theme of 'devotion' therefore contributes to this body of knowledge around how being immersed in motherhood activities and identity can serve as a buffer against DE emergence in motherhood, and beyond pregnancy.

Superordinate theme two: Motherhood as triggering to DE

Alternating between the good and bad effects of motherhood on DE, and sometimes simultaneously, meant that the second superordinate theme 'motherhood as triggering to DE'

encapsulated such difficulties in accordance with the subordinate themes of: 'rocky road', 'frequent guilt', and 'the straw that broke the camel's back'.

'Rocky road' referred to participants' descriptions of the lack of control and stressors as related to the transition to motherhood including pregnancy, the post-partum period and the integration of mothering into day-to-day lives. In previous literature, mothers struggling with DE have mentioned an experience of lack of control over the body's shape and size during pregnancy (or the fear of it; Burton et al., 2015; Patel et al., 2005; Shaffer et al., 2008; Stringer et al., 2010; Taborelli et al., 2016; Tierney et al., 2011). Although most studies indicating a sense of lack of control in the transition to motherhood as part of the DE experience tend to look into pregnancy alone, some have identified similar struggles in the post-partum period, as captured by some of my participants. Namely, mothers in previous studies have also reported the 'shock' at the post-birth body, especially as it was no longer a carrying vessel to the infant, as prompting them to re-engage in DE-behaviours (Taborelli et al., 2016; Willis & Rand, 1988). Participants in my study echoed accounts in other studies regarding a desire to lose weight and engage in DE-behaviours for emotional regulation and a sense of control after giving birth (Taborelli et al., 2016; Tierney et al., 2011). And, the voiced frustration at an inability to satisfactorily engage with intentional weight loss due to a lack of time and energy as a new mother, corroborates experiences described elsewhere (Patel et al., 2005; Stein & Fairburn, 1996). Similarly to other accounts (Patel et al., 2005), my study illustrated mothers' hope that breastfeeding would help 'lose the leftover weight'. Yet, some of my participants conveyed disappointment when breast-feeding did not result in weight loss and instead promoted weight gain due to increased hunger. Unlike some of the experiences described by Stapleton et al. (2008), none of the mothers participating in my study indicated avoiding breast-feeding so that they could engage with compensatory behaviours (e.g., exercising, dieting), despite the subsequent distress that some experienced. Unique to the experience described by some participants in my study was the sense that a loss of control over motherhood extended beyond bodily and dietary concerns (e.g., the baby's needs, mother's sleep times, being at home all day) and formed part of the appeal of DE-related behaviours in early motherhood. All in all, the subordinate theme of 'rocky road' can be understood in terms of popular theories on DE such that individuals may engage more with these when a lack of control is experienced (Button & Warren, 2001; Fairburn et al., 2003; Fox & Power, 2009; Polivy & Herman, 2002). In the case of participants in my study, such lack of control seemed to have been experienced in bodily, lifestyle, and emotional changes during their transition to motherhood.

The subordinate theme of 'frequent guilt' attempted to capture participants' description of guilt due to the consequences of being a primary caregiver on which a little one is dependent physically and emotionally, and how this baseline of guilt in motherhood made DE-related guilt more obvious and/or more intense. The essence of this experience has been described elsewhere in terms of 'fear of failure' (Tierney et al., 2011) and in terms of two aspects of guilt for a mother struggling with DE: 'having a guilty conscience in relation to being a good enough mother' and 'being preoccupied about not involving the children in the eating difficulties' (Rørtveit et al., 2009). Yet, these prior findings did not indicate that mothers understood the re-emergence of DE in terms of guilt in motherhood. Rather, these studies suggested that there is a tug-of-war between DE demands and those of being a 'good enough mother', which, though echoed in another theme in my study ('good enough vs. thin enough mother'), cannot be said to portray a similar meaning to this subordinate theme. As such, this subordinate theme presents novel findings in that mothers described an 'overload' of guilt as being compounded by motherhood concerns which, in turn, exacerbated DE struggles. Such findings could be explained in light of emotional regulation theories on DE (Corstorphine, 2006; Fairburn & Harrison, 2003; Goss & Allan, 2009; Harrison et al., 2010; Hooker & Convisser, 1983), such that the overwhelm of guilt was managed by some participants through DE (e.g., emotional eating, restricting).

Lastly, the 'straw that broke the camel's back' depicted how, in some ways, the stressors experienced in the transition to motherhood and how these posed difficulty in managing DE were unspecific to motherhood. Rather, this subordinate theme illustrated that participants' lives were filled with multiple stressors, and any additional stressor would be emotionally and psychologically taxing and could elicit a re-emergence of DE. The non-specific mentioning of motherhood as another stressor in the mix can be understood in light of DE as a coping mechanism to experiences of a loss of control, and/or as a way to regulate emotions. Yet, an exploration of motherhood stressors as unspecific to DE re-emergence in motherhood had not been mentioned in previous studies. Although it is possible that only mothers in my study reflected that, in some ways, motherhood added stress and a loss of control just as any new stressor might have, it is also important to consider that interview schedules may guide the conversation with participants so as to discuss only specific aspects of the experience. Although a lack of specificity may not shed light onto the relationship between the meaning of motherhood and re-emergence of DE, an understanding of the complexity between multiple stressors is still valuable to growing research. In addition, in order to conduct research that allows for emergence of new theories and gives place to

idiosyncratic experiences, it is important to consider motherhood stressors amongst other stressors. Though I cannot relate this finding to previous studies on re-emerging DE in motherhood, voicing participants' experience may serve as a basis for further exploration with individuals in other contexts, and could refine the provision of support. In essence, this would hone the specificity of interventions as well as the unspecific interventions that may be appropriate for mothers struggling with DE.

Superordinate theme three: Good enough vs. thin enough mother

All participants highlighted an experience of a lack of synthesis between motherhood and DE, as though the two should not occur simultaneously.

'Prioritising children's health' was one derivative of this experience such that self-worth and identity emerging from mothers' DE was often 'sacrificed' in accordance to what the participant thought might be 'best' to minimise its negative impact on her offspring's well-being. It seemed as though participants had to choose where their loyalty resides; if this was with DE or 'putting the child first'. Similarly, Burton et al. (2015) described this aspect of pregnant women's experiences metaphorically as 'walking the tightrope', thus indicating the difficulty of sustaining a balance between managing DE demands whilst prioritising children's well-being. As such, fluctuations in severity of symptoms and the re-emergence of DE in early motherhood were explained by Tierney et al. (2011) and Taborelli et al. (2016) in terms of where women's loyalty lies. Though Tierney et al. considered this as a spectrum of loyalties that differed between their study's groups, participants in my study indicated that this is a flux throughout motherhood (and thus, within the group) and not only during pregnancy. The ongoing struggle to make decisions and 'juggle' between values that underlie DE (e.g., control, emotional regulation, societal thinness ideal) and those in motherhood (e.g., nurturance, education, attachment) can be understood when viewed in this way. The experiences depicted by my participants also suggested that it is not always clear what the best course of action is when it comes to engaging or not with DE in terms of what is 'best' for the children's health and well-being.

Another way in which DE and motherhood was described as though separate was through mothers' voicing of 'guilt over DE in motherhood'; a sense that they brought the 'badness' of DE into the 'goodness' of motherhood. Other qualitative studies on the experience of DE in pregnancy, as well as beyond post-partum, have highlighted this discourse on dichotomising between the 'good' of motherhood and the 'bad' of DE (Rørtveit et al., 2009; Shaffer et al., 2008; Stapleton et al., 2008; Tuval-Mashiach et al., 2013).

Furthermore, considering literature on experiences of mothers struggling with a wide array of mental illnesses (Nicholson et al., 1998), it is not surprising that participants in my study experienced guilt over DE whilst pursuing the valued construct of a 'good enough mother'. Feelings of guilt over the struggle with DE in motherhood seemed to consist of a few elements: guilt for not being 'smitten' entirely by motherhood, guilt for introducing a 'bad' entity (i.e., DE) into the family home, and guilt for having DE pose an obstacle to their availability as a mother. Considering that guilt is an emotion commonly reported in the development and maintenance of DE (Goss & Allan, 2009), as well as in mothers struggling with mental health (Henderson et al., 2016; Tardy, 2000; Vallido et al., 2010), one can only expect high levels of guilt among this population (Rørtveit et al., 2009). Furthermore, the black-or-white categorisation reflected in participants' dichotomy between DE and motherhood seems to reflect a thinking pattern suggested in widely accepted formulations of DE (Waller et al., 2007). My participants reflected on the double-edged sword of self-criticism as part of DE, and guilt for 'bringing' DE into motherhood. Coupled with existing research on stigma as a barrier to identifying and supporting mothers experiencing psychological distress (Clement et al., 2015), and specifically DE (Bye et al., 2018), these findings emphasise the need for space to explore individual mothers' experience of DE.

Participants' reflections on the interweaving between DE and motherhood was also spoken about in terms of the pre-occupation with DE as taking away from their cognitive and emotional availability to be as present with their motherhood as they wished to be. Participants in Patel et al.'s study (2005) similarly discussed that DE-related 'obsessing' meant they were less available to set boundaries and be the educator for their children, as well as be present and engaged in their motherhood experience and bonds with children. Such findings align with theories on cognitive resources, stipulating that the mind has limited capacity (Franconeri et al., 2013). Cognitive psychology could explain this aspect of participants' experience, such that their cognitive and emotional resources are 'used up' through battling DE pre-occupations (Hull et al., 2011). Additionally, research emanating from positivistic epistemologies has suggested that some DE patterns impact alertness and mood. For example, since binge-eating tends to be with foods of high sugar and/or fat content, the individual may have a sugar crash and experience lethargy. Similarly, caloric restriction can result in numbness and poor concentration (Grandjean & Grandjean, 2007). On the other hand, it is possible to speculate that mothers' proclivity to guilt and sensitivity to considering themselves not 'good enough' mothers predisposes an experience of 'looking

for' matching evidence, therefore rendering emotional unavailability more salient (MacLeod et al., 1986).

Lastly, some mothers described the role of societal expectations in giving rise to an ongoing push-and-pull between DE and motherhood. The discussion of two opposing societal expectations as part of the experience of DE in motherhood was touched upon by Tierney et al. (2011) in the sense that there is an expectation to be a slender female on the one hand, and an expectation to be a caring mother on the other. Yet, participants in my study indicated that societal expectations of thinness related to motherhood, and not just to being a woman, in the pressure to revert the body size and shape to how it was prior to pregnancy. A voicing of this pressure as part of the experience of re-emergence of DE in the post-partum period was described in other phenomenological studies (Patel et al., 2005; Taborelli et al., 2016). It has been argued that the urgency to lose weight in the post-partum period relates to the affliction of EDs and the accompanying 'perfectionistic' thinking style (Tierney et al., 2011). Yet, the importance of competing societal expectations was voiced by my participants, who self-reported DE rather than being formally diagnosed with EDs; this suggests that such pressures extend beyond the difficulties limited to EDs. In fact, the studies reviewed here indicated the prevalence of this experience in mothers in Israel and other Western countries, and suggested that conflicting societal demands posed increased difficulty for mothers with a history of DE (Clark et al., 2009; Shloim et al., 2015; Williams et al., 2017). Furthermore, even mothers without a history of EDs or DE have discussed this pressure as mobilising efforts to lose weight (Hodgkinson et al., 2014; Johnson et al., 2004; Lee et al., 2020; Raspovic et al., 2020). Considering findings in my study alongside the discourse in Western countries to restore the 'pre-baby body', it may become ambiguous for mothers who struggle with DE (and do not meet diagnostic criteria of EDs) to know whether they should seek support. It is possible that exposure to such discourse from so-called 'healthy mothers' (i.e., free from DE pre-occupations) blurs the lines to understand when to seek psychological support. In turn, this may introduce another complexity to the process of identifying afflicted mothers and providing support.

Considering the various sub-ordinate themes to this super-ordinate theme, 'being a good enough vs. a thin enough mother', the experiences voiced by participants in my study portrayed a complex interaction between managing DE-related and motherhood-related expectations and sources of self-worth. While motherhood was considered to have both triggering and healing effects on DE, this final super-ordinate theme attempted to convey the co-existence of both the 'good' and 'bad' interactions between the experiences of DE and

motherhood for my participants. All in all, the complexity of this super-ordinate theme may parallel the deliberations and often confusing complexity that mothers struggling with DE experience when navigating re-emerging DE in motherhood, and the ongoing cycle between both aspects of their lived experience. It is important to consider this finding in light of one of the rationales that gave rise to my research; namely, the contradiction in previous findings regarding improvement of DE for some mothers and a worsening of DE for others. Keeping this in mind, the super-ordinate theme 'being a good enough vs. a thin enough mother' indicates that some mothers experience both the healing and triggering aspects of motherhood in DE, and these do not occur independently. Rather, DE in motherhood waxes and wanes as mothers make ongoing compromises that are rarely clear-cut in terms of their impact on the children and the mother herself. To put it simply; the experience of DE on its own can elicit confusion and ambiguity with regards to the balancing act of physical and emotional health, when DE behaviours sometimes promote one without the other in the short-run, but usually come at a detriment to both in the long-run. When experiencing improvements in DE, such considerations continue, as challenging DE can be distressing, yet, one cannot abstain from food as it is essential. For mothers experiencing re-emerging DE, these aforementioned confusing struggles are compounded by considerations regarding modelling physical and mental health to children. Therefore, this super-ordinate theme reflects the difficult compromises that mothers make when experiencing a re-emergence of DE in motherhood.

Limitations

I chose IPA to explore the lived experience of re-emerging DE in the context of motherhood. In the following, I critique IPA in terms of its inherent limitations including the role of language, quality issues, and the use of self. In addition, I discuss the limitations of my study (beyond the general limitations of IPA) within those topics, as well as in a subsection regarding anonymity during recruitment and data collection.

Role of language

As IPA makes use of verbal language to explore lived experiences of phenomena, it is important to consider limitations on this basis. Within a critical realist ontology and phenomenological constructivist epistemology, the use of IPA does not allow for in-depth consideration of language's impacts on the experience described. IPA is primarily interested

in the content of the words used by participants to learn about phenomena, but considers the importance of the context of interviews and the subjectivity of participants. Though IPA does not strive to collect an 'accurate' representation of the experience through interviews, this is nonetheless a critique that can be made when considering that participants' accounts are bound by language. An additional pertinent limitation is that my interviews were conducted in Hebrew, and then translated to English. In the act of translation, my dual role as translator and researcher meant that I intended to capture my understanding of the meaning conveyed by participants such that it remained as similar as possible to participants' Hebrew accounts. Yet, it is important to consider that an inherent limitation is that the translated quotes are no longer the voices of my participants. This limitation goes hand-in-hand with the limitation of writing a piece of research in English, rather than in Hebrew, as academic research in the field is predominantly in English.

Quality issues

According to Yardley's guidelines for assessing rigour in qualitative research, I have followed 'sensitivity to context', 'commitment and rigour', 'transparency and coherence', and 'impact and importance' throughout. As an individual using IPA for the first time, it was often difficult to manage the balance between making descriptive and interpretative comments to provide a rich account while adhering to experiences conveyed by participants. In my initial act of interpretation, I may have felt more comfortable with descriptive comments than interpretative comments, as compared to an experienced IPA researcher. Yet, having engaged in the hermeneutic circle and re-read transcripts gave me an opportunity to refine this skill and provide more in-depth interpretations. Additionally, as a reflexive CoP trainee, I believe I had the experience of interpretations in the therapeutic encounter to provide a base with which to look at data.

As interviews were conducted in Hebrew and then translated to English, the transparency of transcripts can only be evaluated by a Hebrew native. Nonetheless, the choice to be both the translator and the researcher was thought-through and supported by research indicating that this offers an opportunity to experience difficulties in meaning equivalence (Temple & Young, 2004). This dual role was helpful to include such observations in my interpretations. In addition, this served to make sure that translated material conveyed my understanding of the meaning captured by my participants and retained the tone conveyed in Hebrew (Temple, 2005; Venuti, 1993). Lastly, the choice to translate the transcripts rather than to conduct an

analysis in Hebrew and then translate it was informed by my emphasis on the ability for other researchers to assess rigour in my analytic process.

Use of the self

As an Israeli woman that has lived around the world, I cannot describe myself as a "cultural insider" nor as an "outsider" (Smith et al., 2009). On the one hand, this could have bestowed me with an objectivity of a comparison point to other cultures when conducting these interviews, but this is hard to evaluate considering that my family's culture was Israeli. I believe that this enabled me to elicit more information in the interview process than a complete outsider, due to attention to cultural nuances.

Furthermore, as a female who is not a mother, my assumptions in this respect could also have affected the experience of the interview. Despite participants not knowing my not being a mother, it is likely they assumed my gender from my voice. My personal characteristics, history, and philosophical leanings likely affected the research in ways within as well as beyond my control, and in ways that are not aimed to be bracketed in IPA.

Anonymity

Initially, I aimed to conduct online chat-based interviews in order to allow for complete anonymity. In essence, I was hoping that participating mothers would be unaware of my characteristics and know that I am unaware of theirs (other than identifying themselves as mothers struggling with DE) in order to overcome barriers identified previously. Although I initially attempted to recruit in this manner, data collection did not prove fruitful as participants were required to enter a link and follow it at the correct time of the study, without my being able to contact them if any issues arose. As such, this limitation is beyond my abilities as it is currently the case that full anonymity online for such interviews is only feasible for motivated participants with technical aptitude and with ample time to prepare for such a setting. Considering that mothers tend to be occupied, this method for data collection proved ineffective and in retrospect, this is not surprising. Furthermore, my poster's anonymity may have been perceived as 'stranger danger' such that mothers might have been wary of not knowing who I was and whether they may feel comfortable to divulge personal experience of a stigmatised topic. Therefore, providing mothers with an option of either online chat or telephone meant that mothers could choose how they would feel more comfortable. That all mothers opted for telephone interviews might indicate that convenience was more important for my sample. Yet, as a limitation to my study and as relevant to

literature in my rationale, not having an entirely anonymous method may have affected shame in the interview, and thus could have influenced the depth of experience mothers felt safe to share.

Implications and Recommendations

Practice in Counselling Psychology

Though it is not possible to generalise the findings, as my participants' experiences are bound to their idiosyncrasy and the co-constructed interview experience, transferability can be discussed. Specifically, the findings presented here indicate that some mothers may experience a complexity in the interaction between DE and motherhood such that sometimes motherhood may aid remission and other times it may exacerbate aspects of DE. The third superordinate theme suggested that mothers may experience a contradiction between motherhood and DE that contributes to difficulty navigating when both are co-existent. As such, therapy practices with mothers experiencing a re-emergence of DE may benefit from exploring this tension, and work on integrating between 'good' and 'bad' aspects. It may also be helpful for practitioners to explore this experience to strengthen motherhood's positive aspects in its impact on DE, as well as to learn to manage the ways in which motherhood is experienced as triggering to DE. A development of guidelines for such practice would benefit from quantitative research to check whether such experiences are common among Israeli mothers as well as mothers in other countries, and in other periods of time.

Additionally, the findings suggested that mixed messages are delivered on a societal level regarding valuing thinness versus nurturance in the mother. In other words, the expectation for mothers to focus uniquely on the child at the same time as focusing incredibly on appearance. These expectations can also be understood as posing a contradiction between appearing to mother (i.e., spending time bonding with children), whilst still appearing as though the woman has never been a mother (i.e., restoring the 'pre-baby body'). As suggested previously (e.g., Rodgers et al., 2018), it may be useful for medical professionals that are in contact with pregnant mothers to distribute flyers on supporting services for mothers with a history of DE, as well as to normalise the experience of this tension. Such information could be combined with existing provision of similar information regarding postnatal depression.

Considering that findings in my study indicated a sense of guilt for struggling with DE in motherhood, it is important for all involved professionals to be sensitive to a lowered

threshold to guilt in a stigmatising society. As such, if concerns arise regarding an ED in a mother, it is critical for relevant communication to be delivered sensitively in order not to exacerbate the guilt that could be part of the affliction's vicious cycle.

It is also important to consider implications for preventative therapeutic practices. Therapy being conducted with women that are of reproductive ages and who struggle with DE may benefit from exploring expectations as expectant future mothers. Exploring self-critical aspects and a lowered threshold for guilt may enable therapy to provide tools ahead of time. Additionally, due to stigma regarding mental health difficulties in mothers, it is essential for practitioners to normalise the presence of DE-related struggles in motherhood. Therapy with to-be-mothers would therefore benefit from planning towards predicted psychological struggles that would be explored based on the specific needs of clients and their predictions of challenges they may face with regards to DE as a new mother.

Therapy practices with pregnant mothers who report a remission from DE could strengthen the positive aspects of motherhood that are already conveyed by the mother. For example, by considering 'meaning of the body', therapy may benefit from expanding this way of thinking by considering this to be relevant beyond the end of pregnancy and breastfeeding. That is, similarly to the subtheme of 'being available', therapy may build on 'meaning of the body' in later motherhood by considering that caring for her body will contribute to her ability to care for her children at any age, especially if the client indicated a strong valuing of motherhood.

Lastly, by increasing access to psychological therapy for mothers struggling with DE, a societal message of reducing shame and stigma will deliberately be delivered. Furthermore, if practitioners embrace the exploration of DE during motherhood, this discussion in itself may be normalising and contribute to better management of DE struggles. It may prove challenging for practitioners to explore the 'conflict' between DE and motherhood without offering solutions, especially if safeguarding concerns arise. Yet, it is important to conduct risk and safeguarding evaluations and procedures while simultaneously considering that a contribution to the mother's sense of guilt may inadvertently exacerbate these issues. The exploration of these topics (rather than an avoidance) may help clients feel that they are not alone in their struggles, and could contribute to more rational thinking (Reeves, 2015).

Future Research

Research of various types and epistemological underpinnings can contribute to knowledge on the experience of re-emerging DE in motherhood, as well as to the provision of support.

Based on my findings, and their similarity with other findings, the development of questionnaires may be aimed for. Such questionnaires could, for example, evaluate the extents to which motherhood is experienced as triggering and/or healing to DE. These may then be tested for validity in predicting DE struggles in motherhood and overcoming these. In effect, such tools could assess efficacy of therapy, predict the need for support prior to becoming a mother (e.g., if correlations are found with other measures) and indicate who would benefit most from psychological support in services where provision is limited.

Research from social constructionist perspectives can explore discourses such as feminism, motherhood, and aesthetics of thinness, in participants' accounts regarding re-emerging DE in motherhood. Furthermore, DA is well-suited to consider generational holocaust trauma, religion, and women's rights in the relevant contexts of Israeli mothers. Likewise, discourses on balancing between career and motherhood can be examined in Western societies by and large. Another important discourse to consider is shame in mental health difficulties among mothers in general.

Keeping in mind the subordinate theme of 'the straw that broke the camel's back', future research would benefit from considering how other stressors fit together with motherhood changes to 'map out' the stressors in the transition to motherhood. Within a positivist epistemology, such a task of unravelling stressors could be achieved through regression analyses. Research may consider separating the effects of marital changes, career changes, aging, or other factors from the impact of motherhood-specific stressors. Likewise, the context of these stressors can also be tested for, such as considering how the Covid-19 lockdown would have impacted the experience of re-emergence of DE in motherhood, all-the-while considering the aforementioned common motherhood changes.

Additionally, an exploration of this phenomenon in later motherhood (e.g., during the empty nest stage) will be important to better understand the experience of re-emergence of DE throughout motherhood. Though this phase of motherhood is less consequential for safeguarding of children, and potentially the reason for dearth in pertinent research, such an exploration would continue to embody and respect the importance of the individual mother.

From a phenomenological perspective, clinical practice would benefit from research exploring mothers' ideas on what they think would be helpful to explore in therapy.

Furthermore, considering the findings in my study, it may be appropriate to investigate whether and how mothers would like to be asked about their experience of DE in motherhood. In other words, considering the sensitivity of such a highly stigmatised experience, it is important to construct knowledge on how mothers would prefer to experience therapeutic endeavours and how they would like the conversation to be breached. Additionally, considering findings in my study indicating that motherhood and DE can be perceived as contradictory, it remains to be understood on an individual level how any mother may or may not seek to be supported in this push-and-pull. This way, therapy would be founded more so on the idiosyncratic experience, and better embody humanistic perspective and phenomenological outlook.

Preliminary findings here suggested that guilt in motherhood contributed to emotional regulation through DE. Therefore, research should explore how guilt of 'not being available' as a mother (due to DE pre-occupation) may or may not contribute to DE. Mothers in my study suggested that they coped with such guilt using emotional eating. Future studies geared specifically at this could further explore the relationship between motherhood and DE, and how DE is then subsequently experienced as a secondary experience.

Furthermore, future research could compare between re-emergence of DE in motherhood and the experience of mothers who experienced DE for the first time during motherhood. Undertaking such endeavours could broaden our understanding of the specificity of motherhood-related aspects to the experience of DE during motherhood, as opposed to concerns that are more specific to DE.

Conclusions

My study explored the experience of re-emerging DE in the context of motherhood. I used IPA due to its appropriateness to my phenomenological attitude and valuing of idiosyncratic meaning-making. In accordance with the importance of context as well as diversity in this topic, I used IPA to analyse interviews with seven Israeli mothers self-reporting a re-emergence of DE in motherhood. The findings suggested that participants experienced motherhood as healing to DE in some respects, especially in having a different perspective of the function of their bodies, being motivated to serve as a role model to their children regarding healthy relationships with food and the body, and by having a new area of their lives to devote attention to. On the other hand, findings also indicated that participants experienced motherhood as triggering to DE, especially in terms of the difficult changes

during transition into early motherhood, a baseline guilt in motherhood exacerbating a threshold for DE-related guilt, and as a non-specific stressor contributing to an accruing of stressors. A further finding was that participants experienced a difficulty in managing the balance between DE demands and providing 'good enough' mothering. Resultant confusion was based on considering children's health, a guilt over bringing DE into motherhood, being available as a mother, and conflicting societal expectations on thinness and nurturance.

The findings presented here resembled those in previous literature conducted mostly with pregnant mothers, and therefore indicated that these experiences extend beyond bodily changes in pregnancy. The conflicts experienced by participants were similarly discussed in other studies with mothers struggling with EDs, showing that such experiences were present also among my participants who were not diagnosed with an ED. These findings offer insights regarding a back-and-forth between remission and relapse for mothers as reported in previous studies, by considering the meanings participants made of motherhood and its multifaceted aspects.

Having considered the limitations inherent in my study's methodology, I provided recommendations and implications for future research and practice, in order to further expand on the body of knowledge in CoP on this phenomenon and to refine the provision of support for mothers struggling with DE.

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Appendices

Appendix A: Notice of Ethics Review Decision (including request for amendment to initial Ethics Application)

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Milda Perminiene

SUPERVISOR: **Lisa Fellin**

STUDENT: Adi Hannah Sela

Course: Professional Doctorate in Counselling Psychology

Title of proposed study: The meaning of re-emerging disordered eating in the context of motherhood: An Interpretative Phenomenological Analysis

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the

research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

APRROVED WITH MINOR AMENDMENTS

Minor amendments required *(for reviewer)*:

My suggestion is that in the Invitation letter author highlights that the first part of the study is a screening for eligibility part and that not all the respondents will get to the interview stage (so, it would not come as a surprise). Also, if possible, listing potential causes of being prevented from the interview in the debrief form could be helpful for an interviewee to better understand why she wasn't selected.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature): Adi Hannah Sela*
Student number: 1713394

Date: 07/03/2019

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high-risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☐ + LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Milda Perminiene

Date: 07/03/2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

UNIVERSITY OF EAST LONDON

School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant: Adi Hannah Sela
Programme of study: Professional Doctorate in Counselling Psychology
Title of research: The meaning of re-emerging disordered eating in the context of motherhood: An Interpretative Phenomenological Analysis.
Name of supervisor: Dr. Lisa Fellin

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
To interview Israeli participants (in Hebrew) residing in Israel. This would be in addition to English speaking U.K. residents.	Difficulty recruiting participants in the UK; literature review is based on findings in Israel as well; the researcher has more access to communities of mothers in Israel and this may be more promising for recruitment.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): Adi Hannah Sela
Date: 14/07/2019

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	NO
Comments Amendment is approved with the understanding that the interviews will be conducted via teleconferencing technology.		

Reviewer: Dr Rona Hart

Date: 15th July 2019

Appendix B: Invitation Letter (Translated English version and Hebrew Version)

You are being invited to participate in an online research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a Professional Doctorate student in the School of Psychology at the University of East London and am studying for a Professional Doctorate in Counselling Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into women's experience of re-emerging disordered eating during motherhood.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society (2018).

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve mothers who:

- Are aged between 20 and 48
- Have struggled with eating disorders in the past (before motherhood)
- Have experienced a re-emergence of disordered eating during motherhood
- Would describe their relationship status as being stable throughout their motherhood

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to:

1. Complete an **online survey** that is expected to take about **10-15 minutes**. It will include:
    1. A few general questions to confirm your suitability to the study.
    2. Providing your e-mail address or telephone number in order to arrange for an interview taking place on a separate day.

*Therefore, the **first part of this study is a screening for eligibility** and will determine whether the participant is eligible to participate in the second part of the study:*

1. Participate either in a **one-to-one chat-based interview or phone call interview (on the phone or on Skype)** with the researcher. It is expected to take about **45-70 minutes**.
    1. You will be asked to provide an e-mail address or a phone number so that the researcher can arrange an interview with you, and to ask you how you would prefer to be interviewed.
    2. In the interview, you will be asked about your experience of disordered eating specifically during motherhood.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

- Participation is anonymous, as it only requires a phone number or an e-mail address to communicate.
- Participants' I.P. address will not be traced.
- The Skype chat is only available to the researcher and the particular participant
- Collected data will be safely stored, password protected, and encrypted.
- Participants do not have to answer all questions asked of them and can stop their participation at any time during the research.
- Participants can ask to withdraw from the research even after the interview has been completed, and may do so by contacting the researcher at de.motherhood@gmail.com up to 3 months from the date of the interview.

What will happen to the information that you provide?

What I will do with the material you provide will involve:

- Collected data will be safely stored on the researcher's computer, will be password protected and encrypted.
- Data will always be anonymous, as participants are never asked to provide personal information that could identify them (name, address, employment, etc.)
- Anonymised data will be used for analysis, and would therefore be seen by the researcher's supervisors, examiners, and may be published in my doctoral thesis as well as academic papers and presented at conferences.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw I would reserve the right to use material that you provide up until the point of my analysis of the data. Therefore, you may withdraw up to 3 months from the date of the interview, by contacting the researcher at de.motherhood@gmail.com.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me at de.motherhood@gmail.com

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr. Lisa Fellin. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: l.c.fellin@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: m.j.spiller@uel.ac.uk)

מי אני? אני ישראלית, דוקטורנטית לפסיכולוגיה ייעוצית שלומדת באוניברסיטת מזרח לונדון)University of East London(. במסגרת הלימודים שלי אני מנהלת את המחקר שהוזמנת להשתתף בו.

מהו המחקר? אני עורכת מחקר על חוויות של קשיים בהתמודדות עם דיאטה, מבנה גוף, גודל הגוף ו/או משקל אצל אימהות. המחקר שלי אושר על ידי ועדת האתיקה של בית הספר לפסיכולוגיה באוניברסיטה שלי. פירוש הדבר שהמחקר שלי עומד בסטנדרטים של אתיקה אקדמית שנקבעו על ידי האגודה הפסיכולוגית הבריטית)2018(.

מדוע התבקשת להשתתף? הוזמנת להשתתף במחקר שלי כמי שמתאימה לסוג הנשים שאני מחפשת כדי לעזור לי לקדם את נושא המחקר שלי. אני מחפשת אימהות שהן:

- בגילאים 20-48
- נאבקו עם קשיים בהתמודדות עם הגוף או הדיאטה שלהן בעבר)לפני האימהות(
- חוו)או חוות(מאבקים דומים שוב בתקופת האימהות

אני מדגישה שאני לא מחפשת "מומחה" בנושא. אני מבטיחה לך שאני לא אשפוט אותך או אנתח את הקשיים שלך באופן אישי, ושאני אתייחס אלייך ולחוויות שלך בכבוד. את חופשיה להחליט אם ברצונך להשתתף או לא.

איך אפשר להשתתף? אם את מסכימה להשתתף תתבקשי:

1. להשלים <u>שאלון מקוון</u> זה צפוי לקחת כ-5-10 דקות. זה יכלול:
   1. מספר שאלות כלליות כדי לאשר את ההתאמה שלך למחקר.
   2. לרשום את כתובת הדואר האלקטרוני שלך או מספר הטלפון שלך על מנת לתאם ראיון שיתקיים ביום אחר.

לכן, החלק הראשון של מחקר זה הוא סינון עבור לזהות אם את מתאימה להשתתף בחלק השני של המחקר:

להשתתף בראיון אישי איתי. הריאיון יתקיים בעברית)או באנגלית(דרך הטלפון או באמצעות שיחת צ'אט בסקייפ)מה שתעדיפי!(. הריאיון צפוי לקחת 45-70 דקות. תתבקשי לרשום כתובת דואר אלקטרוני או מספר טלפון, כך שאוכל לתאם ראיון אתך, ולשאול אותך כיצד היית מעדיפה להתראיין)זאת אומרת: בטלפון או בצ'אט(. בראיון, תישאלי על החוויה הרגשית שלך של אכילה ושל הגוף שלך במיוחד במהלך האימהות.

לצערי, אני לא אוכל לשלם לך על השתתפותך אבל ההשתתפות שלך תועיל מאוד למחקר שלי, ותוכל לעזור לעצב עתיד תומך יותר לאימהות שמתקשות עם נושאים דומים. השתתפותך מאוד חשובה לי - תודה רבה שהקדשת זמן לקרוא קצת על המחקר שלי. מקווה לדבר אתך בקרוב.

השתתפותך במחקר בטוחה וסודית

פרטיותך ובטיחותך יכובדו בכל עת.

3. ההשתתפות היא אנונימית ודורשת רק מספר טלפון או כתובת דואר אלקטרוני כדי לתקשר
4. כתובת ה.I.P שלך לא תופיע
5. שיחת הצ׳אט בסקייפ תהיה זמינה רק לעורכת המחקר ולמשתתפת
6. הנתונים שיאספו יהיו מאוחסנים בבטחה, מוגנים באמצעות סיסמה ומוצפנים
7. המשתתפת לא חייבת לענות על כל השאלות, ויכולה להפסיק את השתתפותה בכל עת במהלך המחקר
8. המשתתפת יכולה לבטל את השתתפותה במחקר גם לאחר סיום הריאיון, ויכולה לעשות זאת עד 3 חודשים ממועד הריאיון על ידי פנייה לעורכת המחקר בכתובת דוא״ל de.motherhood@gmail.com

מה ייעשה עם המידע שתספקי?

- נתונים שיאספו יישמרו בבטחה במחשב של עורכת המחקר, יהיו מוגנים בסיסמה ומוצפנים
- הנתונים יהיו אנונימיים, מכיוון שהמשתתפת מתבקשת לא לספק מידע אישי שיכול לזהות אותה)שם, כתובת, תעסוקה וכדומה(
- נתונים)אנונימיים(ישמשו לניתוח איכותני, ולכן ייראו על ידי מפקחי המחקר והבוחנים, יפורסמו בתיזה של עורכת המחקר, ואולי יופיעו בעבודות אקדמיות ויוצגו בכנסים.

אם תרצי לבטל את השתתפותך

- את חופשיה לבטל את השתתפותך במחקר בכל עת ללא הסבר, וללא השלכות. את יכולה לבטל את השתתפותך במחקר עד שעורכת המחקר תתחיל את שלב ניתוח הנתונים של כל המשתתפות במחקר. זאת אומרת, ניתן לבטל השתתפות עד 3 חודשים מיום הריאיון, על ידי יצירת קשר עם עורכת המחקר de.motherhood@gmail.com

פרטי קשר

אם את מעוניינת במידע נוסף על המחקר שלי או אם יש לך שאלות כלשהן, אנא אל תהססי לפנות אלי בכתובת הדוא״ל de.motherhood@gmail.com

אם יש לך שאלות או חששות לגבי האופן שבו המחקר נערך, פני למנחת המחקר ד״ר ליסה פלין.

Dr. Lisa Fellin. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: l.c.fellin@uel.ac.uk

או

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: m.j.spiller@uel.ac.uk)

Appendix C: Participant Consent Form (Translated English version and Hebrew version)

1. I have the read the information page relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

○ I consent (1)

---

2. I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

○ I consent (1)

---

3. I hereby freely and fully consent to participate in the study which has been fully explained to me.

○ I consent (1)

---

4. Having given this consent, I understand that I have the right to withdraw from the study up to three months after the date of the interview and without being obliged to give any reason. I understand that if I withdraw within this time frame, the researcher will not use my data. I also understand that should I wish to withdraw after the three-month period; the

researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

○ I consent (1)

טופס הסכמה

1. קראתי את דף המידע של המחקר וקיבלתי עותק ממנו. המחקר ומטרותיו הוסברו לי, והייתה לי הזדמנות לדון בפרטים ולשאול שאלות. אני מבינה במה כרוכה השתתפותי, והנהלים שבהם אני אהיה מעורבת הוסברו לי.
2. אני מבינה שההשתתפות שלי במחקר זה, ונתונים מסוימים ממחקר זה, יישארו חסויים לחלוטין. רק לחוקר)ים(המעורבים במחקר תהיה גישה לזיהוי נתונים. קיבלתי הסבר מספק לגבי הנהלים שיתבצעו לאחר השלמת המחקר.
3. אני מסכימה להשתתף במחקר זה בחופשיות ובאופן מלא.
4. אני מבינה כי יש לי את הזכות לבטל את השתתפותי במחקר עד שלושה חודשים לאחר מועד הריאיון, מבלי שאצטרך לתת סיבה או הסבר. אני מבינה שאם אבטל את השתתפותי במסגרת שלושת החודשים הללו, עורכת המחקר לא תשתמש בנתונים שלי. אני גם מבינה שאם ארצה לבטל את השתתפותי במחקר אחרי שלושת החודשים הללו, עורכת המחקר שומרת את הזכות להשתמש בנתונים האנונימיים שלי בעבודת המחקר שלה.

Appendix D: Recruitment Leaflet

University of East London

UEL

MOTHERS, YOUR VOICES DO MATTER

Do you find yourself concerned with your diet? body shape? body size? weight?

Have you struggled with these before motherhood, and again as a mother?

Please share your experience with me (anonymously)

TO PARTICIPATE, SCAN THIS CODE WITH YOUR CAMERA

or go to

tiny.cc/mothers2019

Appendix E: Qualtrics Screening Survey

Start of Block: Default Question Block

Q1 Are you a mother?

- Yes (1)
- No (2)

Skip To: Q14 If Are you a mother? = No

Q2 Number of children

_____

Q3 Please enter your age

- Age (1) _____

Q4 Have you previously struggled with disordered eating? (for a definition of disordered eating, please enter https://www.eatingdisorders.org.au/eating-disorders/disordered-eating-a-dieting)

- Yes (1)
- Maybe (2)
- No (3)

Skip To: Q14 If Have you previously struggled with disordered eating? (for a definition of disordered eating, pl... = No

Q5 Please briefly describe your previous struggles with disordered eating

_____

_____

_____

_____

_____

Q6 Have you experienced struggles with disordered eating during motherhood?

- Yes (1)
- Maybe (2)
- No (3)

Skip To: Debrief form If Have you experienced struggles with disordered eating during motherhood? = No

Q7 Are you currently experiencing disordered eating?

- Yes (1)
- Maybe (2)
- No (3)
- *Skip To: Debrief Form, If Have you experienced struggles with disordered eating during motherhood? = No*

Q8 Please briefly describe your struggles with disordered eating during motherhood

_____

_____

_____

_____

_____

Q9 Please take a moment to think about your previous and current struggles with disordered eating. Did you experience an improvement in between these episodes?

- ○ Yes (1)
- ○ Maybe (2)
- ○ No (3)

Q10 Please indicate the trigger(s) for your most recent struggles with disordered eating.

_____

_____

_____

_____

_____

Page Break

q11 Do you live in the UK?

- ○ Yes (30)
- ○ No (31)

Display This Question:

If Do you live in the UK? = No

Q12 What country do you live in?

_____

Q13 Please enter your e-mail address and/or a U.K. based phone number (if you have one), so that the researcher may contact you. The researcher will contact you to ask you whether you would prefer to conduct the interview through chat or via telephone (international phone calls would be conducted via voice call on Skype), and to arrange for a suitable date and time.

- e-mail address (1) _____
- U.K. phone number (2) _____
- Other (please specify) (3) _____

Q14 Thank you for your participation, and I hope to speak to you soon! If you have any further questions or hesitations please contact the researcher at de.motherhood@gmail.com

Appendix F: English (Translated) Interview Schedule

Example Interview Schedule (Questions and *Prompts)*

- What kinds of feelings/thoughts do you associate with being a mother?
- *Tell me about your experience of being a mother and what kind of challenges you've experienced*
- What is your understanding of 'disordered eating'?
- What kinds of feelings/thoughts do you associate with your disordered eating?

- How have you experienced your disordered eating in challenging times during motherhood?
    - What sense do you make of the presence of your disordered eating in these times?
    - How have you coped with that?
    - (*If particular concerns in the context of motherhood were mentioned→)* How do these concerns impact your disordered eating?

(Other versions of the above questions listed below, depending on the flow of the interview):

- What is your experience of disordered eating during motherhood? ***OR*** How do you understand/what sense do you make of the disordered eating that has re-emerged during your motherhood? ***OR*** What do you understand about the re-occurrence of disordered eating during your motherhood?
- Did you experience your previous and current disordered eating in the same way? *(Follow up question→)*
    - What are the differences/similarities between the disordered eating you experienced in the past and the disordered eating you experienced during motherhood?

- Following up: ideas about impact, aetiology, explanations
    - Some research/theories/other mothers suggest such and such explanations (emotional regulation, loss of control, bodily changes/lifestyle changes in motherhood), is this your experience? What are your ideas about it? Would you have anything else to add to that? It would be interesting to see what you think about these.

- How do you feel about having experienced disordered eating as a mother?
    - *Follow up question:* how have these feelings impacted your disordered eating?

- Anything else you would like to add that you think is important and/or that we didn't cover?

Appendix G: Hebrew Interview Schedule

שאלות לראיון

- איזה מחשבות/רגשות את מקשרת לאימהות?
- תספרי לי על החוויה שלך של אימהות ועל סוג האתגרים שחווית
- מה הבנתך לגבי 'קשיים בהתמודדות עם הגוף/המשקל/דיאטה'?
- איזה סוג של מחשבות או רגשות את מקשרת לקשיים עם הגוף/משקל/דיאטה?
- איך חווית את הקשיים האלו בתקופות מאתגרות באימהות?
- מה את מבינה מזה שחווית קשיים עם הגוף/משקל/דיאטה שלך בתקופות האלו?
- איך התמודדת עם זה?
-)אם ישנן דאגות ספציפיות באימהות(—< איך הדאגות האלו משפיעות על הקשיים שאת חווה עם הגוף/משקל/דיאטה שלך?

- מה החוויה שלך של הגוף/משקל/דיאטה שלך במהלך האימהות?
- מה את מבינה מזה שחווית קשיים עם הגוף/משקל/דיאטה מחדש בתקופת האימהות?
- מה את מבינה מהתחדשות התופעה של הקשיים האלו בתקופת האימהות?
- האם הקשיים שחווית לפני האימהות היו דומים או שונים לקשיים שחווית בתקופת האימהות? מה משותף ומה ההבדלים?

- איך את מרגישה עם זה שחווית קשיים עם הגוף/אכילה/דיאטה שלך בתור אימא?

איך השפיעו הרגשות הללו על הקשיים שלך עם הגוף/אכילה/דיאטה? איך התמודדת עם הרגשות האלו?

Appendix H: Debrief Letter (English Translated version)

Thank you for your time and participation in the online survey and in our chat-based interview. The data you provided is valuable to my learning and could be used to inform the wider field of research and therapeutic practices for mothers experiencing re-emerging disordered eating.

Your anonymised data will be safely stored on the researcher's computer, will be password protected, and encrypted. Anonymised data will be used for analysis, and would therefore be seen by the researcher's supervisors, examiners, and may be published in academic journals.

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw I would reserve the right to use material that you provide up until the point of my analysis of the data. Therefore, you may withdraw up to 3 months after the date of our interview (**RESEARCHER WILL INSERT DATE FOR PARTICIPANT**), by contacting the researcher at de.motherhood@gmail.com and requesting to withdraw.

If you would like support with disordered eating, please contact **Nofit** (detailed below). If you feel that you are in distress and may not be able to keep yourself or others safe, please contact **Eran** or **Sahar** (detailed below).

- **Nofit:** Nofit is a centre for the treatment of eating disorders in Hod HaSharon in Israel. The service provides information, help and support. Their helpline staff are trained in the field and are there to listen, as well as provide information about sources of help available.
    - **Web:** http://www.nofit.org/Default.asp?sType=2&PageId=11593
    - **Helpline:** +972 97447111
        - Helplines are open 09:00 – 19:00. If the line is busy, please leave your phone number and you will be contacted as soon as possible.

- **Eran:** Confidential support for people experiencing feelings of distress or despair. Free 24/7 hotline available: please dial 1201. Eran also offers anonymous online chat support available Sundays-Thursdays from 10:00 – 02:00 and Fridays-Saturdays from 14:00 – 02:00. Help is also available at those days and times through SMS support: please text +972 76 88444 00. Eran also offers non-urgent support (up to 2 business days to respond) via e-mail, or by accessing support from other individuals on their forum.
    - **Website:** https://www.eran.org.il/

- **Sahar**:
  Confidential support for people experiencing feelings of distress or despair. Free chat service available from 21:00-24:00. Please e-mail sahar.help@gmail.com if you would like support outside of the chat hours.
    - Website: www.sahar.org.il

  In an emergency please contact your doctor or go to your nearest A&E department.

Thanks again for your participation

Appendix I: Example Analysis Process

(R = researcher, P = participant)

	Transcript	*Line*	Exploratory Comments	Emerging Themes
P	Correct, correct, I have no choice, it is choosing between one evil and another, that is the feeling. Ehm, well, over time I have to say that it is more flashy but many times that I find myself more angry I suddenly realise that I am hungry, but sometimes it is in delay. Ehm.. But I need like to go eat to calm down and so that I can be in a better mood and I won't.. You know, it is a very very difficult feeling, to feel that you are angry around the kids not because they are doing something not right or difficult or a difficult day or something like that, rather simply because you are not taking care of yourself or.. Eh, eating enough, or pre-occupied with something silly like.. How many calories did I eat today? So that also of course creates guilt, these things. Yes? Easily.. Well, motherhood is saturated with guilt but.. Eh, ehm.. I think that in that area, I have.. I have really a feeling of choice. Between them and myself. And it is difficult. Eh…	129 130 131 132 133 134 135 136 137	Guilt over anger at children; guilt that anger at children is due to own DE Responsibility over own DE Guilt over focusing on food/body -> self-criticism that it is silly DE as taking focus away from more valued things such as motherhood meaning Guilt over DE in motherhood -> yet another source for guilt in motherhood DE vs. motherhood = myself vs. them	Guilt at DE-based anger expressed towards children Self-criticism at 'silly' focus on body/food DE taking focus away from meaning in motherhood and life Guilt over DE in motherhood as one of many motherhood guilts DE vs motherhood = myself vs the children
R	And when you feel those feelings of guilt when you think that you got mad and.. And you feel guilty about it, how do you cope with that guilt? I am wondering if that feeling also enters the eating or..	138 139		
P	Good question. It is possible, it is possible. The truth is I hadn't thought about it. I suppose so, I suppose that in some way.. I don't know if it.. That is, it is possible that it also impacts the hunger in a concrete way but I.. Sometimes I just, you know, sometimes I feel that in the guilt there is something in it.. She (the guilt) creates ingredients of self-destruction. Eh and then.. The eating is.. It is undoubtedly the best friend of the.. The mechanism of self-destruction. *Talks to baby: I hope you don't understand what we are talking about, I hope (chuckles), I hope that you don't suffer like this* ehm, so yes.. Sometimes it is like that.. Sometimes it is like.. And sometimes you know, in order to calm down, I need to eat.. It.. Then, sometimes I eat more than I planned and then I get bummed out over that..	140 141 142 143 144 145 146 147	Guilt over DE in motherhood in turn exacerbates emotional eating Guilt over DE in motherhood -> vicious cycle	Guilt over motherhood DE vicious cycle with emotional eating
R	Mmmhm	148		
P	Sometimes yes it is like a vicious cycle.. Ehm, I.. Again, I have to say that.. After the second pregnancy, it was the hardest. The most extreme. Both of my children were little, it was the most complicated. Now I feel it less, and whether it was after the first pregnancy that way, I don't really remember. Just after the second pregnancy it was the hardest. It also was.. Really difficult, that is.. I slept the least at night which really impacts eating. Very very much so. The topic of hours of sleep it really affects. It really.. Like, if I sleep less, I am way hungrier. Way hungrier, significantly.	149 150 151 152 153 154	DE struggles worsen as motherhood stressors increase More motherhood stressors -> more susceptible to DE Reduced sleep due to motherhood changes -> more susceptible to guilt-inducing eating	Stressors in motherhood exacerbate susceptibility to DE struggles Motherhood lack of sleep -> guilt-inducing eating
R	Yes. And also in that time you had two young children, ehm.. And you had lots to do.	155		
P	Yes, I was terribly hungry, terribly tired. And yes, my husband was doing his specialisation, it was.. It was less of a good period and then I was screwed ('I ate it') and I felt those feelings more. The more complicated feelings. It was.. And that's why I say that it is a vicious cycle because it, each in its turn exacerbates the other, exacerbates the first, exacerbates the other.. It's like.. A mess.	156 157 158 159	Life stressors compound to motherhood stressors -> increased risk of DE DE exacerbates life stressors (vicious cycle)	Stressors in motherhood + life stressors = increased risk of DE DE and life + motherhood stressors as vicious cycle

Appendix J: Presentation Key of Participants and Themes

Super-ordinate themes	Sub-ordinate themes	Participant						
		Hazel	*Ivy*	*Juniper*	*Poppy*	*Sage*	*Sakura*	*Yasmin*
Motherhood as healing to DE	Meaning of the body		✓	✓	✓	✓	✓	✓
	Being a role model	✓	✓	✓	✓		✓	✓
	Devotion		✓	✓	✓	✓	✓	✓
Motherhood as triggering to DE	Rocky road	✓	✓	✓	✓	✓	✓	✓
	Frequent guilt	✓		✓		✓	✓	✓
	The straw that broke the camel's back	✓	✓		✓		✓	✓
Good enough vs thin enough mother	Prioritising children's health	✓	✓	✓	✓	✓	✓	✓
	Guilt over DE in motherhood	✓	✓	✓	✓	✓	✓	✓
	Being available		✓	✓	✓	✓	✓	
	Societal expectations		✓	✓	✓		✓	✓